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The Impact of Social Stigma on the Therapeutic Relationship for Latino Clinicians: The Elephant in the Room?

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THE IMPACT OF SOCIAL STIGMA ON THE THERAPEUTIC RELATIONSHIP FOR LATINO

CLINICIANS: THE ELEPHANT IN THE ROOM?

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ABSTRACT

Social stigma is consistently mentioned in the literature as one of the barriers preventing Latinos from seeking, accessing and remaining in mental health care. This study focuses specifically on social stigma as a barrier to remain in psychotherapy. Social stigma is understood as the internalized fear of severe social disapproval for behaving against acceptable cultural meaning systems. With intersubjective theory as the analytical framework, this study primarily explores, through a series of focus groups with Latino mental health service-providers of Latino clients, the perceptions those practitioners have regarding the influence of social stigma on the therapeutic relationship and the ways they address this issue in their practice. The constant comparison method from a grounded theory perspective and the software NVivo, as an auxiliary, were used for data analysis. It was found that social stigma is perceived by participants as inextricably linked to the engagement process. It is not seen as playing a significant role in the dropout of clients from therapy. Participants see themselves as responsible for engaging their clients and eventually addressing any barriers they may bring to the therapeutic encounter, including social stigma. The most common strategies reported by participants to fulfill these responsibilities are the use of flexible boundaries when interacting with clients, and the use of psychoeducation to inform them about the meaning and implications of the therapeutic process. Participants

strongly recommend the use of groups as a therapy modality for effectively engaging

clients and addressing the issue of social stigma.

CHAPTER ONE

INTRODUCTION TO THE STUDY

Background

Hispanics[1] are not only the largest, but also the youngest and fastest-growing

minority in the United States (U.S. Census Bureau, 2008). Additionally, and in general,

Latinos present similar prevalence levels of mental health issues when compared to the

levels observed in other population groups, though they receive less mental health care

(National Healthcare Disparities Report, 2005; the National Latino and Asian American

Study, NLAAS). Therefore, Latinos constitute a significant and sizable population in

need, yet underserved by the mental health system (Rosenthal, 2004). The

development of mental health strategies and interventions aimed to address the needs

of this youthful population are essential not only for Latinos, but for the overall health

and productivity of the United States (National Council of La Raza, 2005).

Several barriers prevent Latinos from seeking, accessing, and remaining in

mental health care. One barrier is social stigma, which is understood as the internalized

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[1] Hispanics and Latinos are terms used interchangeably in this document. They refer to all persons of Cuban, Mexican, Puerto Rican, South- or Central American, or other Spanish-speaking cultures of origin, independently if they were born in the US. In the 1970s, the U.S. government established the use of the term Hispanic to classify all persons of Spanish cultural roots, including all persons of Latin American origin (DHHS, 1999). The federal government considers race and Latino origin to be separate and distinct concepts (Office of Minority Health, 2006).

fear of severe social disapproval by behaving against acceptable cultural meaning systems.   Social stigma, as a mental health service barrier, is rooted in the practice of some cultural values such as *dignity, respect, familialismo* (being family-oriented) and *aguante* (the ability to withstand stressful situations during difficult times), upheld by most of the Latino population (Añez, Silva, Paris, & Bedregal, 2008; Van Hook, 1999; Grote, Zuckoff, Swartz, Bledsoe, & Geible, 2007; Ojeda & McGuire, 2006; McKay, Stoewe, McCadam, & Gonzales, 1998; Choi & Gonzales, 2005).

Despite the suggestion based on current research that Latinos benefit from mental health services, they nonetheless present high rates of dropping out of psychotherapy. Psychotherapy is one of many mental health services, and the focus of this study. An underlying assumption of this study that is based on Intersubjectivity theory, which constitutes this study's theoretical framework, is that addressing social stigma in psychotherapy is a clinician's role which has a direct impact on the therapeutic relationship.   Furthermore, the clinician's failure to fulfill this role may prevent the therapeutic process from moving forward successfully and eventually lead to therapeutic impasses, attrition, and early, abrupt terminations by clients.

The Study of Conceptual Framework: Intersubjectivity Theory

This study relies on Intersubjectivity for its theoretical framework. In particular, the study draws from Intersubjectivity its understanding of the therapeutic encounter and the role of the clinician in it. Intersubjectivity understands the therapeutic

encounter as one in which the internal and external realities of both client and clinician, including their cultural worlds, either explicit or implicit, are intertwined and interact. As a consequence, it is understood that all therapeutic interactions emerge and are affected by the relations between client and clinician. A solid relationship between client and clinician has been found to be one of the most significant predictors for positive outcomes in therapy.

Intersubjectivity stresses the clinician's responsibility in making a conscious effort to recognize and address issues brought to psychotherapy by clients as a critical element in facilitating the formation of a solid therapeutic relationship and therefore in improving the odds of a positive outcome for the client (McKay et al., 1998; Grote et al., 2007). Social stigma, as a construction which comes from and belongs to the cultural world, is one of those issues that may be brought to the therapeutic encounter by clients, affecting it, and challenging the clinician ability to be responsive to it. When the therapeutic process is not moving in the direction of achieving therapy goals or ends abruptly, Intersubjectivity focuses on how the situation is co-constructed by client and clinician and explores how the situation is addressed by the clinician. With its understanding of the therapeutic encounter and the role of the clinician in it, Intersubjectivity Theory provides a suitable theoretical frame for an exploration of the impact of social stigma on the therapeutic relationship for Latino clinicians, the focus of this study.

Intersubjectivity theory is conceptualized as a psychodynamic theory, a variation within the psychoanalytic tradition (based on Freud's theories), in general, and part of what is known as relational theories, in particular.   Psychoanalytic and psychodynamic theories share a common conceptual frame. Both theories recognize the existence of a dynamic unconscious, deal with transference and counter-transference, and see early life experiences as crucial in the development of human beings.

Intersubjectivity, interpersonal, object relations, self psychology, and various integrations (Greenberg & Mitchell, 1983) are considered relational theories. These theories are considered post-modern because they reflect a paradigm switch from positivistic to relativistic science or from objectivism to constructivism (Hoffman, 1998). They emphasize, among other things, that all therapeutic action emerges and is affected by the relations among those interacting (Beebe, Jaffe & Lachmann, 1992; Fosshage, 1992, 1995; Greenberg, 1995).

Relational theories contrast with the traditional psychoanalytic approach. The traditional psychoanalytic approach emphasizes the drives and the intrapsychic world of clients. Relational theories share the basic premise that all psychological products take place in systems constituted by interacting worlds. They posit that in normal and pathological psychological development, transference, counter-transference, and therapeutic action all emerge within and are affected by relational interactive systems (Fosshage, 2003).

Atwood & Stolorow (1984) coined the term *intersubjectivity* in reference to the field of intersection between two subjectivities, the interplay between different subjective worlds. In their book *Contexts of Being* (1992) they elaborated the difference between Freud's theory and Intersubjectivity. Departing from what the authors called the "four foundational pillars of psychoanalytic theory"—the unconscious, mind-body relations, trauma, and fantasy—they resituate these foundational constructs within an intersubjective perspective.

The main difference between Psychoanalytic theory and Intersubjectivity is rooted in their understandings of the intrapsychic. For Intersubjectivity, the intrapsychic world forms and evolves within a nexus of living systems and therefore is profoundly context-dependent. Psychoanalysis does not recognize this interconnectivity and perceives the intrapsychic as a more isolated element. This difference has significant implications at several levels particularly regarding the understanding of the therapeutic relationship and the role of the clinician in it.

The original intersubjective perspective had five developmental moments, each punctuated by a book: *Faces in a Cloud* (Atwood & Stolorow, 1979), *Structures of Subjectivity* (Atwood & Stolorow, 1984), *Psychoanalytic Treatment* (Stolorow, Brandchaft & Atwood, 1987), *Contexts of Being* (Stolorow & Atwood, 1992), and *Working Intersubjectively* (Orange, Atwood & Stolorow, 1997). The most relevant of these books in terms of the proposed study is *Psychoanalytic Treatment* in which the

authors applied the theoretical principles to clinical issues such as transference and resistance and therapeutic action. This book explains how, from an intersubjective perspective, the clinician cannot be an objective, neutral observer without affective participation as understood by the Freudian perspective. On the contrary, client and clinician form an indissoluble psychological system and none can be studied alone. In this system, the totality of the client-clinician relationship becomes inextricably intertwined.

Intersubjectivity theory differs from other psychodynamic theories in that it does not offer an explanation of personality development or pathogenesis. It offers principles for investigating and comprehending the intersubjective contexts in which psychological phenomena occur. It is focused on the contextual process which occurs in the encounter between a client and a clinician. This contextual focus includes the interacting, subjective worlds of client and clinician, particularly the clinician's theories and the cultural worlds of both participants.

In a further development of Intersubjectivity theory, Jessica Benjamin (1990, 2004, 2005) a theoretician with a strong feminist influence, has provided some elements to understand the clinician's role in facilitating the formation of a solid therapeutic relationship and therefore in improving the odds of a positive outcome for the client. She emphasizes (2005) that the active co-creation of consensus or conflict about reality between client and clinician produces a different emotional experience of connection.

She states it is the clinician's responsibility to make a conscious effort to recognize and address the issues brought to psychotherapy by the client.

Benjamin (2004) elaborates how clinicians build relational systems and develop the intersubjective capacities for such co-creation and therefore the experience of profound connection with clients. She says this is done through *surrender* which implies the ability to take in the other's point of view or reality. Benjamin sees *surrender* not as something clients need to do, but a conscious work done by the clinician aimed to build a shared third with the client. Hence, it is crucial for clinicians dealing with clients bringing to the therapeutic encounter issues such as stigma to make a conscious effort to recognize and address them in order to build a therapeutic relationship able to facilitate the best outcomes for the client. Because this study focuses on the perceptions of clinicians upon some aspects of the encounter with their clients and, furthermore, the study intends to draw attention to the role of clinicians in addressing social stigma in psychotherapy, particular attention is given to Benjamin's perspective.

Statement of the Problem

The United States is an ethnically diverse country. Currently, minorities account for 34 percent of the U.S. population. However, the actual percentage may be more because it is not clear how many of the undocumented immigrants who have entered the country have been included in that figure. Among the minority ethnic groups, estimates as of July 1, 2007 indicate that Hispanics grew by 1.4 million in 2007 reaching

a total of 45.5 million people, or 15.1 percent of the total U.S. population of 301.6

million. Non-Hispanic blacks ranked as the second-largest minority group, at 37 million

people (U.S. Census Bureau, 2008). The Latino population has increased by 58 percent

since 1990, compared with an increase of 13 percent for the total U.S. population

(Guzman, 2001), making Latinos the fastest-growing minority in the United States. In

addition, Hispanics are considerably younger than other groups. They had a median age

of 27.6, compared with the population as a whole at 36.6. For African-Americans, the

median age was 31.1; for Asians, it was 35.4; and for Caucasians, it was 40.8. It is

expected that by 2030, Latinos will comprise an estimated 20 percent of the U.S.

population (U.S. Census Bureau, 2008). In 2050, under the latest U.S. Census Bureau

projection (2009) which takes into account the recession and stricter immigration

policies that have slowed the flow of immigrants into the U.S., the total population of

the country would climb to 399 million with Caucasians accounting for 49.9 percent of

the nation's population, African-Americans for 12.2 percent, Asians for 6 percent, and

Latinos for 28 percent of the total population. Others would comprise the remaining 3.9

percent.

Latinos in the United States are significant for human services providers not only

because of their number, but also because they have increased morbidity and mortality

rates, high incidence of suicide, school dropout, alcohol use, illicit substance abuse, and

HIV infection (Centers for Disease Control and Prevention Office of Minority Health,

2005; Martinez, DeGarmo, & Eddy, 2004; Substance Abuse and Mental Health Services Administration, 2005; Añez et al., 2008). Several large-scale surveys assessing the mental health of Latinos indicate significant rates of affective disorders, substance abuse/dependence, and anxiety disorders in this population (Rosenthal, 2004). In addition, research on lifetime prevalence rates of psychiatric disorders among Latinos has consistently demonstrated that the incidence is comparable with that of non-Latino whites and also tends to increase over length of residence in the United States (Alderete, Vega, Kolody, & Aguilar-Gaxiola, 2000; Alegria et al., 2007; Burnam, Hough, Karno, Escobar, & Telles, 1987; Vega, Kolody, Aguilar-Gaxiola, &Catalano, 1999; Grant et al., 2004). These trends have far-reaching implications to which the mental health field needs to be aware and responsive.

Despite a high service need, disparities in access to care have resulted in patterns of low utilization and frequent dropout in mental health services among Latinos. Research in the 1990s showed that fewer than 1 in 11 Latinos with a mental disorder contacted a mental health care specialist and that less than 1 in 5 obtained general service for mental health problems (U.S. Department of Health and Human Services [USDHHS], 2001). In the case of Latino immigrants (those born outside the United States), the research showed that only 1 in 20 searched for help (Vega et al., 1999). Rates of mental health service use among Latinos appear to have increased substantially over the past decade relative to rates reported in the 1990s, particularly

for those diagnosed with certain psychiatric disorders (Añez et al., 2008). Nevertheless, even after controlling for other predictors of service use, the gap in mental health service utilization between minorities and Caucasians remains substantial (Miranda & Cooper, 2004; Smedley, Stith, & Nelson, 2003; Husaini, Sherkat, & Levine,2002). This is particularly acute for Latinos who are foreign-born, more recent immigrants, primarily Spanish speakers, without health insurance coverage, and with no diagnosis of mental illness (Añez et al., 2008). Furthermore, among those Latinos who get assistance, only one in four receives adequate treatment (USDHHS, 2008). Therefore, it is critical to more deeply explore those issues preventing Latinos from not only accessing mental health services but to remain in care, receiving appropriate treatment.

Several barriers prevent Latinos from seeking, accessing, and continuing to receive mental health services. Among the most commonly-mentioned barriers are those related to cost, language, location, transportation, poverty, level of acculturation, child-care, lack of culturally-responsive mental health providers, and social stigma (Añez et al., 2008; Shattell, Hamilton, Starr, Jenkins, & Hinderliter, 2008; Van Hook, M., 1999; Grote et al., 2007; Ojeda & McGuire, 2006; McKay et al., 1998; Choi & Gonzalez, 2005; Cabassa, Lester, & Zayas, 2007). It is paramount to take into account the significance and impact of the barriers faced by ethnic minority parents in the mental health care for their children (Yeh, McCab, Hough, Dupuis, & Hazen, 2003).

The lack of bilingual, culturally-responsive mental health providers to Latinos in the United States is a barrier relevant for this study, which has as one of its goals to draw clinicians' attention on their role dealing with social stigma in psychotherapy. The lack of bilingual, culturally-responsive clinicians has serious implications for social work and other professions aimed at providing care to vulnerable populations and for those in charge of their education and training. Only 29 Latino mental health professionals exist for every 100,000 Latinos. In striking contrast, there are 173 mental health professionals for every 100,000 Anglo-Saxons (USDHHS, 1999). Membership characteristics from psychology and social work professional organizations further exhibit the extent of the disproportion between Latino service recipients and Latino practitioners (Añez et al., 2008). In 2005, the American Psychological Association reported that 2.1 percent or 1,860 members, identified as Hispanics. Data from the National Association of Social Workers Center for Workforce Studies estimated that although Latinos constitute only 4 percent of licensed social workers, approximately 77 percent of all social workers reported having Latino clients on their caseload (Whitaker, Weismiller, & Clark, 2006). The existing mental health system is greatly challenged to develop culturally and linguistically congruent services that will effectively address the needs of a diverse Latino community. As an initial step, mental health practitioners face the complex task of engaging an often high-need and underserved population (Añez et al., 2008).

More research is clearly needed as to whether different types of barriers are significant to remaining in psychotherapy. This study focuses on one of the most commonly-mentioned barriers, namely social stigma. Social stigma is understood in this study as the internalized fear of severe social disapproval by behaving against acceptable cultural meaning systems, norms about mental health issues and treatment (Sirey, Meyers, Bruce, Alexopoulos, Perlick, & Raue, 1999; Choi & Gonzalez, 2005; Ojeda, 2006; Grote et al., 2007; Shattell et al., 2008). It is inextricably linked to the sense of embarrassment about discussing personal issues with others—nearly one-half of minorities report they are embarrassed about discussing their problems with others, a rate nearly four times that of Caucasians (47% vs. 12% respectively)— (Ojeda & McGuire, 2006).

Social stigma, as a mental health-services barrier, is rooted in the practice of some cultural values upheld by most of the Latino population (Añez et al., 2008; Van Hook, 1999; Grote et al., 2007; Ojeda & McGuire, 2006; McKay et al., 1998; Choi & Gonzales, 2005). It is recognized by this study that cultures have central tendencies, but culture is also varied, dynamic and contextualized. Here culture is understood to indicate that *on the average*, it is more likely that a person from a particular culture (in this case, a Latina person) will display more of a particular characteristic, i.e. a tendency to defer to the wishes of others, than a person from another culture where that value is less prevalent (Lieberman, 1990).

Cultural meaning systems were described by Falicov (1998), as "a set of premises about what is believed or thought to be preferable in human behavior and processes among people that share a similar sub-culture or ecological niche" (p. 14). These systems contain cognitive, emotional, and motivational components. When a motivational component is recognized as being linked with a cultural value, a possible link between values and behaviors emerges. The Latino cultural values of *Dignity, Respect, Familialismo*, and *Aguante* lead most Latinos to conform to acceptable social norms, to endure with stoicism personal problems and to avoid discussing them, which could compromise their sense of pride, potentially embarrassing them in front of others (Ojeda & McGuire, 2006). When problems are discussed, it is expected it will not occur outside of familial boundaries, save for their medical doctors and/or their spiritual counselors such as priests and pastors (Añez et al., 2008). The popular saying in Spanish, "dirty laundry is to be washed at home" reflects this reality.

Despite the presence of social stigma, some Latinos do, in fact, seek out and start receiving psychotherapy. One assumption of this study is that the reception of care does not necessarily imply that social stigma has been overcome and that this barrier does not need to be addressed in psychotherapy. For example, and to the contrary, Latinos are sometimes referred to psychotherapy by their medical doctors, spiritual counselors, or other authority figures. As a result, individuals may feel both the obligation to attend psychotherapy at least once so as to satisfy whoever referred them,

and also the increased perception of their problems as being more serious and

therefore, more private. They may start missing appointments, may not be willing to

contribute to the therapeutic process and even drop out of psychotherapy. Clinicians

provide different explanations for these situations. Some tend to blame the client by

attributing the actions to mechanisms of defense such as resistance, or blame

themselves with explanations of the untimely use of a specific technique. It is necessary

to further explore these explanations and others to evaluate if they suffice or if

alternative reasons such as the impact of social stigma on the therapeutic relationship

exist for attrition. Therefore, exploring the impact of social stigma on the therapeutic

relationship from the clinicians' perspective becomes a crucial first step in order to be

responsive to the attrition issues in psychotherapy.

Beyond its immediate implications, when clients do not receive the mental

health services they need, the entire society at large pays a heavy cost, not only

financially, but also in terms of social dysfunction and human suffering (Pekarik, 1985).

From a financial stand point, mental health providers rely heavily upon certain minimum

levels of activity and flow of material resources, to enable basic levels of care. When

short-circuited by "non-engagement," the latter being understood as when clients seek

services, schedule an appointment, and then fail to keep it or reschedule (Masi, Miller,

& Olson, 2003) these systems become compromised, disabling the expedience and

effectiveness of services. When left unaddressed, the personal, marital, and family

problems may eventually evolve in a dangerous, if gradual spiral, culminating in

increased mortality rates (Meng-ning et al., 2006) through, among other things,

depression, family conflict, substance abuse problems, and suicide (Keicolt-Glaser and

Newton, 2002; Mueck-Weymann, Moesler, Joraschy, Rebensburg, & Agelink, 2002;

Thase, Salloum, & Cornelius, 2001). In the end, human suffering is not alleviated, fees

are increased and the cost-effectiveness of mental health services delivery decreases

(Evans, 1999). Addressing the issue of social stigma in psychotherapy is one way to

positively impact mental health service delivery to the Latino population.

This exploratory study is focused on the Latino population in general, rather than

a specific ethnic group. Furthermore, the researcher is a Latino clinician with some

experience providing services to different sub-groups within the Latino population in

terms of their national origin, race, financial situation, and educational and

acculturation levels. Based on this experience, it is believed that social stigma is a

common barrier to remain in therapy for the Latino population in general. It is also

believed that stigma is expressed and impacts in similar ways all different categories of

Latinos. It is recognized, however, that the researcher experience is limited and that in

fact there might be differences in both the quantity and the quality of the impact of

social stigma upon different sub-groups of Latinos. Therefore, those differences may be

reflected in the therapeutic relationship they establish with their clinicians.

Purpose of the Study

This study explored (1) the perceptions of Latino mental health service-providers regarding the influence of social stigma in psychotherapy with Latino clients; and (2) the ways Latino mental health clinicians address this issue in their practice. Furthermore, this study considered the role of clinicians in (1) addressing social stigma in psychotherapy and (2) identifying strategies for dealing with this issue. The ultimate aim of this research is to improve mental health service delivery to the Latino population.

Little is known about the impact social stigma has on the therapeutic relationship. The real implications of social stigma and the clinician's responsibility in addressing this issue with clients have been rarely noted. It is the purpose of this study to begin to address this lack of connection, drawing clinicians' attention to their role and identifying strategies for dealing with this issue.

An underlying assumption of this study is that addressing or disregarding social stigma in psychotherapy has an impact on the therapeutic relationship and therefore in the occurrence of either positive psychotherapy outcomes or issues such as attrition or abrupt termination of the process. Another underlying assumption of this study is that clinicians seldom purposefully address the issue of social stigma once the therapeutic encounter has begun, though they sometimes unconsciously may intervene to

overcome it. By raising awareness to these unconscious interventions, clinicians may make them more effective and efficient when used in the therapeutic encounter.

In the end, this research aims to improve mental health service delivery to the Latino population, a significant and sizable population in need yet underserved by the mental health system.   Towards this end, the study was designed to explore some little known aspects of a broader topic: social stigma as a barrier for Latinos to remain in mental health care.

The specific research questions for this study are: (1) What is the impact of social stigma on the therapeutic relationship? (2) How do clinicians address social stigma in psychotherapy?

Definition of Terms

In this study, operational definitions for the terms are as follows:

Mental Health Services

Before defining mental health services it is necessary to start with a definition of mental health. Such a definition is particularly difficult taking into account that several factors, especially cultural differences and competing professional theories affect how mental health is defined. In fact, as Cowen (1994) points out, the overt and covert expressions of values which vary from culture to culture, among cultural sub-groups and among individuals, make any universally acceptable definition a mere illusion. Adding to

the difficulty of achieving a unified definition of mental health is the recognition that this notion is intertwined with that of mental illness.

This study fully embraces the notion that mental health and mental illness are not polar opposites but points on a continuum (U.S. Department of Health and Human Services, 1999; Fellin, 1996). Within that continuum, **mental health** is understood as a state in which an individual achieves a sense of well-being coming from the realization of his or her own abilities, the use of his or her coping mechanisms to deal with the normal stresses of life, the possibility to be productive and fruitful through his or her work, and his or her contributions to the community (World Health Organization, 2005). As part of the same continuum, **mental illness** refers collectively to all diagnosable mental disorders. **Mental disorders** are health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder are called **mental health problems** (U.S. Department of Health and Human Services, 1999).

Based on the previous definitions, **mental health services** are defined as specialized services which are specifically designed for consultation and/or intervention on mental health problems or mental disorders and/or the promotion of mental health (Australia Department of Health and Ageing, 2005). Mental health services include a vast array of services such as psychiatric wards of general hospitals, in-patient care in

psychiatric facilities, supported housing with full or partial supervision, prescription medication, local primary care medical services, self-help groups for mental health, and psychotherapy.

This study focuses on the relationship which emerges between the participants in one of those mental health services: psychotherapy (most commonly referred to as therapy). **Psychotherapy** is broadly defined as "the relief of distress or disability in a one person by another, using an approach based on a particular theory or paradigm, and that the agent performing the psychotherapy has had some form of training in delivering this" (Jerome, 1988). It is understood in this study that psychotherapeutic training must be complemented with formal legal recognition. Psychotherapy can be performed by a variety of practitioners, such as clinical social workers, counselors, and psychologists. The general term used in this study for those practitioners providing psychotherapy is **clinician**. The general term used in this study for those attending psychotherapy is **client**.

Social Stigma

Social stigma is initially defined in this study as the internalized fear of severe social disapproval by behaving against accepted cultural meaning systems, norms about mental health issues and treatment. This initial definition was evaluated after the study data was analyzed. And eventually lead to a new or revised definition.

The concept of stigma has been applied to an enormous array of circumstances, and by a multitude of individuals coming from different fields, each one emphasizing different aspects of the notion. This reality has led to a variety of conceptualizations of stigma. The definition used in this study acknowledges these conceptualizations and incorporates some of them, with a focus on the field of psychotherapy, and specifically on the therapeutic relationship. Furthermore, the definition used focuses on the perspective of the individual who perceives him/herself as at risk of being stigmatized for attending psychotherapy. Finally, the operational definition was developed around the person-in-the-environment principle of the social work profession.

The definition of stigma has evolved, departing from the seminal work of Erving Goffman. Goffman (1963) defined stigma as an attribute which discredits and reduces the bearer from being like anybody else to becoming a "tainted, discounted one." Other authors such as Jones, Farina, Hastorf, Marcus, Miller & Scott (1984) see stigma as a mark (attribute) that links a person to undesirable characteristics (stereotypes). Link & Phelan (1999) added the component of discrimination to the Jones, et al (1984) definition.

Stafford & Scott (1986) link the notion of stigma to the contradiction of a norm and understand norm as the social shared belief in regards to the expected behaviors of a person under certain circumstances. This understanding of stigma is almost identical to the notion of cultural meaning systems adopted in this study, based on the work of

Falicov's (1998). Cultural meaning systems are described by Falicov (1998), as "a set of

premises about what is believed or thought to be preferable in human behavior and

processes among people that share a similar sub-culture or ecological niche" (p. 14).

Because these systems contain cognitive, emotional, and motivational components, the

thought of transgressing a cultural norm elicits emotional reactions even before the

actual transgression occurs. The fear of consequences impacts the individual's behavior.

This is the main reason why the definition proposed by this study links stigma with the

anticipated fear of social sanctions even if they have not occurred or perhaps will not

occur.

Crocker, Major & Steele (1998) offered a comprehensive review of the view of

sociologists on stigma. They link stigma to a social identity which is devaluated in a

particular social context. This specific understanding emphasizes the environmental

implications for a person when he or she becomes involved in a stigmatized behavior

and constitutes the main support for the use of the expression "social stigma" rather

than "stigma" in this study.

The most common components of the notions of stigma given by sociologists

and social psychologists are labeling, stereotyping, separation, status loss, and

discrimination (Link & Phelan, 2001). According to Link and Phelan (2001), for stigma to

occur, the five elements formerly mentioned have to co-occur and power must be

exercised. This is the major difference between the definition of stigma as applied to

psychotherapy in this study and the more prevalent understanding of stigma among

sociologists and social psychologists as stated by Link and Phelan (2001). The definition

of stigma used in this study does not require co-occurrence and exertion of real power.

On the contrary, based on the perceptions of their social environment, accurate or not,

actual or not, individuals can separate themselves and behave as if they were

stigmatized even before the feared event occurs. It is implicit in the definition

employed in this study that the internalized perception of social stigma becomes stigma

itself in the form of self-stigmatization.

More recently, the concept of moral experience has been added as a component

of the notion of stigma (Yang, Kleinman, Link, Phelan, Lee, & Good, 2007). It is stated

by these authors that stigma exerts its core effects by threatening the loss or diminution

of what is most at stake, or by actually diminishing or destroying that lived value. This

perception seems to be more in alignment with the definition of stigma used in this

study. Indeed, the perception of a threat compromising a cherished value is at the core

of the study definition. In particular and in regards to being in psychotherapy, for

Latinos it refers to challenge the cultural values of *dignity, respect, familialismo* (being

family-oriented) and *aguante* (the ability to withstand stressful situations during difficult

times).

It is an assumption of this study that because psychotherapy is frequently

associated with mental illness, it has an effect on the way in which stigma impacts those

attending psychotherapy. This assumption is based on the work of Corrigan (2005) and Hinshaw (2007), particularly the strategies suggested by Corrigan for assessing and diminishing self-stigma, and the issue of responsive treatment elaborated by Hinshaw.

Summary

Latinos are the largest, youngest and fastest-growing ethnic minority in the US. They present similar prevalence of mental health issues as those of other ethnic groups, yet they receive less mental health care. One of several forms of mental health care, and the focus of this study, is psychotherapy. Even though some Latinos have access to psychotherapy, they present high drop-out rates. Among many barriers preventing Latinos from remaining in psychotherapy, this study focuses on one of them, namely social stigma. Social stigma among Latinos is rooted in some cultural values uphold by most of this population. Social stigma is understood as the internalized fear of severe social disapproval by behaving against acceptable cultural meaning systems.

This study uses Intersubjectivity as its theoretical framework. Based on this theory, it is understood that clinicians have the responsibility to explore and address issues such as social stigma, which may be brought to psychotherapy by clients. Clinicians' responsiveness to clients' issues such as social stigma impacts the therapeutic relationship and therefore therapy outcomes since one of the best predictors of positive therapy outcomes is a strong therapeutic relationship.   One assumption of this study is that often clinicians either do not fulfill this responsibility or do it in an unconscious way.

This study primarily aims to explore the impact of social stigma on the therapeutic relationship for Latino clinicians when providing services to Latino clients and explores how those clinicians deal with this issue in psychotherapy. Furthermore, this study highlights the role of clinicians in addressing social stigma in psychotherapy and identifying strategies for dealing with this issue. The ultimate aim of this research is to improve mental health service delivery to the Latino population.

CHAPTER TWO

LITERARTURE REVIEW

Latinos in Psychotherapy: Social Stigma, Engagement, and Dropout

Current research suggests that mental health services can benefit Latinos, though great controversy exists regarding the best modalities of treatment for this population (Rosenthal, 2004; Navarro, 1993; Ponterotto, 1987). Despite presenting similar prevalence levels of mental health issues to the levels of other population groups, Latinos receive fewer mental health services (National Healthcare Disparities Report, 2005). The most comprehensive study about ethnic and cultural disparities in mental health prior to 2005, was presented in 2001 at the Annual American Psychological Convention, when the Surgeon General released the document "Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General" (U.S. DHHS 2001, Executive Summary, p.12). This study documented that African Americans, Latinos, Asian Americans, and Native Americans had less access to and availability of mental health services; that they were less likely to receive needed mental health services; and that those who were in treatment often received a poorer quality of mental health care. Furthermore, it clearly stated that among the relative few minorities who receive mental health services, a significant portion fail to receive continuous care. Authors such as Gallager-Thompson, Solano, Coon, & Arean (2003)

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have confirmed that disrupted care continues to be a significant issue for those Latinos

who have overcome the barriers to initial access to mental health care. The literature

has identified several barriers for the Latino population to seek, access, and remain in

mental health care. Social stigma is consistently mentioned as one of those barriers

(Añez et al., 2008; Shattell, Hamilton, Starr, Jenkins, & Hinderliter, 2008; Van Hook, M.,

1999; Grote et al., 2007; Ojeda & McGuire, 2006; McKay et al., 1998; Choi & Gonzalez,

2005; Cabassa, Lester, & Zayas, 2007). Very little research has been published in regards

to the effects of stigma on the use of mental health services by ethnic minorities in

general, and Latinos in particular (Corrigan, P., Thompson, V., Lambert, D., Sangster, Y.,

Noel, J. G., & Campbell, J., 2003). One study examined the impact of stigma related to

mental illness among primary care clinic patients with depression (Roeloffs, C.,

Sherbourne, C., Unützer, J., Fink, A., Tang, L., & Wells, K. B., 2003). The sample of the

study consisted of insured English- or Spanish-speaking adults presenting at one of 46

primary care clinics for treatment of depression. The study found that African

Americans were more concerned than individuals from other ethnicities about the

impact of stigma when a history of depression was disclosed. It also found that concern

over stigma did not affect use of mental health service, medical visits for emotional

reasons, or appropriate use of antidepressant medication. It is important to highlight

that participants in the study were insured individuals already looking for treatment of

depression.

Social stigma is not well-defined in the mental health-related literature, though several descriptions found in articles can be understood as referring to it (Sirey, Meyers, Bruce, Alexopoulos, Perlick, & Raue, 1999; Choi & Gonzalez, 2005; Ojeda, 2006; Grote et al., 2007; Shattell et al., 2008). To address this gap, both in building upon the existing literature and adding to it, this study provides a definition of stigma as the internalized fear of severe social disapproval by behaving against acceptable cultural meaning systems, norms about mental health issues and treatment.

Social stigma is a barrier associated with cultural values upheld by most of the Latino population (Añez, Silva, Paris, & Bedregal, 2008; Van Hook, 1999; Grote, Zuckoff, Swartz, Bledsoe, & Geible, 2007; Ojeda & McGuire, 2006; McKay, Stoewe, McCadam, & Gonzales, 1998; Choi & Gonzales, 2005). This statement reflects the agreement of this study with cultural barriers as a theory which explains, at least partially, the underuse of therapy by Latinos. In a review of mental health practices among ethnic minorities, Leong, Wagner & Tata (1995) identified three possible explanations for the underuse of mental health services among these populations—underuse was understood as both not looking for services and not returning after the initial visit. One of the explanations is cultural barrier theory. According to this theory, there are factors in the Latino culture which make it more difficult for Latinos to seek counseling professional services. Those factors are: the use of alternative resources such as family, priests/pastors, and folk healers; lack of acculturation; and traditional cultural values.

However, it is important to mention that some studies challenge cultural barrier theory (Atkinson, Lowe, & Matthews, 1995; Gim, Atkinson, & Whiteley, 1990; Keefe, & Casas, 1978; Ponce, & Atkinson, 1989; Ramos-Sánchez, Atkinson, & Fraga, 1999; Ruelas, Atkinson, & Ramos-Sánchez, 1998). This possibility was considered in the analysis of the data in this study.

A recent article (Ramos-Sánchez & Atkinson, 2009) reports the findings of a quantitative study which examined the relationship between Mexican acculturation, cultural values, gender, and help-seeking intentions among Mexican American community college students. The sample consisted of 262 Mexican American community college students from three central California educational institutions. One hundred-twenty-nine students were from English as a second language (ESL) courses, and 133 students were from social science courses. It is reported that many—but not exactly how many—students from the ESL courses were older individuals from the community who wanted to learn English and were not working toward a degree. The data was collected during class time using a survey which had been translated into Spanish. The instruments used for data analysis were: the *Acculturation Rating Scale of Mexican Americans-II, Multiphasic Assessment of Social Constructs-Short Form, Religiosity Index, Attitudes Toward Seeking Professional Psychological Help-Short Form,* and the *Modified Personal Problems Inventory.* The findings in this study contradict culture barrier theory. They suggest that as Mexican Americans lose their culture of

origin and increase their generational status; their attitudes toward help seeking become less favorable. Furthermore, the findings suggest that adherence to traditional Mexican culture and cultural values may actually encourage help seeking. The authors offer as a possible explanation for this finding the Latino cultural value of personalismo. It is their understanding that the high value given in the traditional Latino culture to the establishment of relationships in opposition to the more individualistic Anglo culture makes traditional Latinos more help-seeking friendly.

Social stigma is also usually associated with attrition and abrupt termination of psychotherapy, one of many mental health services (U.S. Department of Health and Human Services [USDHHS], 2001; Vega et al., 1999; Añez et al., 2008). However, a study by McCabe (2002) found that perception of mental health stigma failed to be associated with dropout.

It is difficult to determine the specific incidence of attrition in psychotherapy because of the different definitions of attrition given by the authors. The terms dropout and attrition are used interchangeably by authors. Most studies define it as leaving therapy before a specified number of sessions though that number varies from one study to another and even within studies (e.g., Beckham, 1992; Hatchett, Han, & Cooker, 2002; Tryon, & Kane, 1993). Many authors define it as consumer-initiated termination without therapist agreement regardless of the number of sessions

completed (Berrigan, & Garfield, 1981; Pekarik, 1992; Richmond, 1992; Tutin, 1987).

The understanding of this author is the latter.

Issues such as attrition and abrupt termination of psychotherapy are considered

failures of the engagement process, an ongoing activity in the therapeutic relationship.

According to the more traditional conceptualizations (Bordin, 1979; Hatcher,

1999; Meissner, 1996), the quality of the therapeutic relationship is the extent to which

the patient and therapist are able to collaborate on therapeutic tasks and goals, as well

as the quality of the bond (the extent to which the patient feels understood, respected,

etc).

Others have argued that it is conceptually better to think about the therapeutic

relationship in terms of negotiation rather than collaboration (Safran & Muran, 2000).

The idea that the alliance is negotiated between the therapist and client on an ongoing

basis highlights the fact that the alliance is not a static variable. Furthermore, Safran

and Muran (2000) have argued that this ongoing process of negotiation between patient

and therapist at both conscious and unconscious levels is an important change

mechanism in and of itself, insofar as it helps patients learn to negotiate the needs of

self and others in a constructive fashion, without compromising the self or treating the

other as an object. This process of negotiation of needs in the therapeutic relationship

thus plays an important role in helping clients to develop some capacity for

Intersubjectivity (i.e., the capacity to experience both self and other as subjects) and to

develop a true capacity for intimacy or authentic relatedness (see Benjamin, 1990, 1995; Muran, 2001; Safran, 1993, 1999). This understanding of the therapeutic relationship is consistent with the theoretical framework used in this dissertation.

Regardless of the specific understanding of the therapeutic relationship, most authors state that an effective engagement process is necessary to form a strong therapeutic relationship, which is considered by many as the most important predictor of positive outcomes in psychotherapy (Baldwin, Wampold, & Imel, 2007; Clement, 2008; Krause & Lutz, 2009). Conversely, weak or poor therapeutic alliances are associated with increased dropout (Johansson, & Eklund, 2005; Lambert, & Barley, 2001; Lingiardi, Filippucci, & Baiocco, 2005; Meier, Donmall, McElduff, Barrowclough, & Heller, 2006). In spite of consistent evidence that the quality of the therapeutic alliance predicts treatment outcome (Cecero, Fenton, Nich, Frankforter, & Carroll, 2001; Horvath & Symonds, 1991; Martin et al., 2000), some authors have a more sober perspective about its relevance as the determinant factor in predicting psychotherapy outcomes (Safran & Muran, 2006). According to them, correlations in the area of .25 (approximately 6% of the outcome variance) do not indicate a whopping effect. Therapist allegiance effects seem to account for much more of the outcome variance, up to 10% (Robinson et al., 1990), and as much as 9% of the outcome variance (Wampold, 2001). Therefore, clinicians' role should provide a more intriguing lead, suggesting potentially productive research avenues.

Nevertheless, some authors sustain that therapist techniques, client involvement, and the therapeutic relationship are inextricably intertwined and need to be considered together in any discussion of the therapeutic process (Hill, 2005). This dissertation fully embraces the idea that that to better understand premature termination and continuity, more attention needs to be paid to how the therapeutic relationship develops (Snowden, & Yamada, 2005). It also agrees that the therapeutic alliance and the role of ethnic and cultural differences in its successful formation seem promising areas for further study (Martin, Garske, & Davis, 2000).Furthermore, in spite of the attention given to the engagement process, little is known about the impact social stigma has upon it and in general, upon the therapeutic relationship (McKay et al., 1996; Baruch, 1997; Wang et al., 2006; Paris, Añez, Bedregal, Andres-Hyman & Davison, 2005; Thompson, Bender, Lantry & Flynn, 2007). With its limitations, this study attempts to address this gap.

It is broadly recognized in the literature that the engagement process of ethnic minorities—and Latinos, in particular—requires the provision of culturally-sensitive services by culturally-responsive providers (McKay et al., 1998; Grote et al., 2007). Developing a hypothesis about the cultural influences on a client can help therapists become more responsive to the needs and expectations of ethnic minority clients, potentially increasing alliance and reducing the high rate of early termination (Sue, 1977). Highly ethnocentric therapists (i.e., focused solely on their own cultural

experience and perspective) are more likely to lose patients to premature dropout

(Baekeland, & Lundwall, 1975).

One of the characteristics of culturally-responsive providers consistently

mentioned by the literature is their ability to effectively address the barriers brought to

treatment by clients (Lopez et al., 2008; Cabassa, et al., 2007; Ojeda & McGuire, 2006;

Grote et al., 2007; Shattell et al., 2008; Añez et al., 2008). Some attempts have been

made by researchers to explore how some of the barriers should be addressed by

clinicians: i.e., in the case of low-income English- and Spanish-speaking Latinos with

depression, adding case management to the treatment protocol (Miranda, Azocar,

Organista, Dwyer, & Arean, 2003).

There is a widespread notion that ethnic match between client and clinician

improves treatment continuity. This belief has been challenged by Maramba & Hall

(2002). In a meta-analysis review, they concluded that ethnic matching was not an

important predictor of premature termination and treatment intensity.

Rarely has the research focused on specific ways to address stigma (Grote et al.,

2007; Shattell et al., 2008). One of the very few studies related to specific interventions

to overcome stigma referred to Korean immigrants with schizophrenia in New York (Shin

& Lukens, 2002). The study found positive effects from a psychoeducational program

adapted for the population under study. This dissertation attempts to partially address

the research gap in Latino therapeutic dyads.

Next, some of the specifics regarding stigma and cultural sensitivity are more developed, pointing out the findings, gaps, and inconsistencies in the reviewed published literature.

Stigma and Other Mental Health Barriers in Latino Children

Several articles related to barriers from seeking and accessing mental health services among minorities—particularly Latinos—have been focused on specific populations. Authors such as Mary McKernan McKay jointly with others (1996, 1998) have written articles focused on inner city children of color. Based on an extensive literature review dating from 1983, these authors explain the underutilization of mental health services based on "the stigma associated with counseling services, the lack of information regarding available services, inaccessible locations, unresponsive service providers, and the reliance on alternative methods of help" (1998, p.10). These articles do not further elaborate on the meaning of stigma as a barrier associated with counseling services. They do, however, emphasize the need for therapists who are able to assess and respond to clients' expectations for treatment since, as they state, this is a factor directly related to treatment engagement and outcome. A recent article (Lopez, Dewey, & Painter, 2008) reported on an integrative review of current literature from child psychiatry and nursing. It mentions as barriers common to children of all backgrounds in accessing mental health services "stigma, cost, insufficient coverage for services from private health insurances, and inadequately trained mental health

providers" (p. 138). Yet, the article does not explain either what stigma is or how it becomes a barrier to access mental health services. The article does highlight, however, how cultural differences can exacerbate the difficulties in accessing mental health services. Citing federal and state of Illinois government-funded studies, the article stresses the need to examine affected groups, identify and address any cultural barriers or challenges, and provide culturally competent care as a way to eliminate or reduce racial and socio-economic disparities in accessing mental health services.

Stigma and Other Mental Health Barriers in Elderly Latinos

The literature about older adults has increased substantially in recent years. A recently-published study (Choi & Gonzalez, 2005) explores the perceptions of geriatric mental health clinicians of barriers and contributing factors to retention of older minorities in treatment. In addition to physical/functional health problems as barriers to continued treatment, clinicians reported lack of desire and motivation for treatment, sense of shame and stigma and fear of mental health treatment, discomfort with psychotherapy, perception of socio-economic and cultural distance between Caucasian therapists and clients, desire to maintain the role of a sick person, resistance from adult children, and the perception or expectation of quick cure. A significant difference between this article and the others already mentioned is that it focuses specifically on barriers to remain in treatment, not to access in general. Stigma is mentioned as one of those barriers. Stigma is not clearly defined by the authors, but they seem to associate

it with a sense of shame. Among several recommendations to promote the

continuation of treatment, these authors report that clinician's observations of the need

for more bilingual/bicultural and culturally competent counselors. The findings in this

article about stigma as a barrier associated with treatment discontinuation support the

findings stated by Sirey and colleagues (1999) in regards to elderly patients with

depression.

Stigma and Other Mental Health Barriers in Depressed Latinos

There is a clear interest in studying depression among Latino adults—especially

women— reflected in the literature. A study regarding women's help-seeking patterns

for depression (Van Hook, 1999) found stigma to be one of the two major barriers to

seeking help. The other major barrier was a perceived separation between mental

health and general health. For Latinos taking anti-depressants, a recent study (Cabassa

et al., 2007) reported a strong perception of stigma associated with it. According to the

study, Latinos believe that taking the medication implies a more severe illness and a

weakness or failure to cope with problems. This is consistent with and confirms other

findings reporting a strong link between stigma and Latino cultural values. However, the

study does not define stigma. Another recent study (Ojeda & McGuire, 2006),

concerning adults who meet clinical criteria for major depression or dysthymia,

indicates that outpatient mental health and substance use services used by minorities

was most affected by "financial and social barriers (e.g., stigma)" (p. 211). When

elaborating on social barriers, the article indicates they "included perception of whether individual can be helped, embarrassment about discussing problems with others, and worries about whether employer will learn of use of treatment for mental health and substance use" (p. 214). The article does not clearly define stigma, but it seems to present two distinctive elements as its constituents. One is the community implication of classifying stigma as a social barrier; the other is the more personal issue of feeling embarrassed by talking about personal problems with others. Another study (Grote et al., 2007) about engaging women of color and Caucasian women who are depressed and living on low incomes arrived at similar conclusions to those of Ojeda. The article by Grote and colleagues distinguishes between practical, psychological, and cultural barriers to care. This article is innovative in not only enumerating the different barriers, but suggesting engagement strategies to overcome them. It indicates that stigma should be addressed, but falls short in presenting a comprehensive engagement strategy for dealing with stigma. It limits the strategy to providing information about the causes—depression as not being a woman's fault—and the treatability of depression. The article is also innovative in its elaboration on the notion of stigma as a psychological barrier to care. The authors point out that the public widely endorses stigma about mental illness. They describe those stigmas as the portrait of depressed and mentally ill people who are incompetent, crazy or violent, but nonetheless in control of and responsible for causing their condition. The authors recognize that

depressed individuals may internalize those negative attitudes endorsed by society and avoid seeking treatment or discontinue treatment prematurely.

Stigma and Other Mental Health Barriers in the General Latino Population

A community-based participatory research project (Shattell et al., 2008) identified factors affecting the access, use, and perception of mental health services by a Latino population in Greensboro, North Carolina at individual, organizational, and community levels. The article found among the barriers at the individual level, "health beliefs about mental illness and care" and at the organizational level, "lack of culturally competent care" (pp. 351-352). When elaborating on the individual level barriers, the article reports that Latinos are "often reluctant to disclose significant complaints or problems" (p. 358). When describing community level factors, the article indicates that they include, among other things, "socio-cultural norms that influence individuals' values, beliefs and attitudes" (p. 355). When elaborating on the community level factors, the authors point out "extended family members in the community sometimes, however, exerted a negative influence on the mental health practices of Latinos. Mental illnesses were often perceived as shame brought onto the family" (p. 363). Even though the authors do not define stigma, they provide some crucial elements for doing so. This article is significant because it is not limited to exploring the barriers to mental health care services. It discusses the implications of those barriers. It reaffirms previous research in regards to the need for trust and rapport in order to establish a therapeutic

relationship. Furthermore, it indicates that trust and rapport can be established

through the understanding and incorporation of specific cultural constructs. In the

specific case of Latinos, the article supports the incorporation of the cultural constructs

of *familismo* and *personalismo* as a way to help Latino clients feel more comfortable

disclosing problems. This incorporation process calls for culturally-responsive mental

health providers. According to this article, "appreciating the importance of cultural

constructs in mental health care delivery, improve the delivery of culturally competent

mental health care, and reduce mental health disparities" (p. 364).

Cultural Sensitivity

The issue of being aware of and effective in responding to cultural differences

has been discussed in the literature of different professions. In the mental health field,

it has been referred to as cultural competency (Sue, Carter, Casas, Fouad, Ivey, Jensen,

LaFramboiset, Manese, Ponterotto & Vazquez-Nutall, 1998). More recently, it has been

called cultural responsiveness (Zion & Kozleski, 2005). A classic article elaborating on

culturally-sensitive interventions with children and families as an indispensable

ingredient in successful interventions with members of other cultures was written by

Alicia Lieberman (1990). This article refers to cultural sensitivity, from the clinician's

perspective, as a form of *interpersonal sensitivity* (p. 104), an attunement to the specific

idiosyncrasies of another person. This attunement has two components: knowing about

the specific content of the other's idiosyncrasies and keeping an attitude of openness

about finding out what we do not know. The whole culture, in addition to the person's personal story, becomes the area of inquiry. But learning about the objective culture is not enough. A clinician needs to know about the interface between the person and the culture: how the individual perceives his/her own culture and to what extent she/he consciously identifies with it or feels herself as a representative of it. Since stigma is an internalized social construction it is crucial for a culturally responsive clinician to explore the degree to which the individual client has incorporated as his/her own such a construction. It is important to note that from Intersubjectivity theory perspective, which is the theoretical framework used in this research, not only the conscious, but also the unconscious identifications with the culture are relevant and constitute part of the therapeutic inquiry.

The Research Questions

As a result of the literature review and the aim to explore some little known aspects of a broader topic: social stigma as a barrier for Latinos to remain in mental health care, the specific research questions for this study are: (1) What is the impact of social stigma on the therapeutic relationship? (2) How do clinicians address social stigma in psychotherapy?

CHAPTER THREE

METHODOLOGY

Design

This study explored some possible answers to the research questions through qualitative research using structured focus groups. One key element in the study was to obtain the perceptions of clinicians to better understand the issue posed and address the research questions. The nature of the exploration led to the choice of qualitative research (Neuman, 2000), as the method of inquiry. In contrast to quantitative methods which can be considered "data condensers," qualitative methods are "data enhancers." When data is enhanced, it is possible to see key aspects of cases more clearly (Ragin, 1994) and to better understand on a personal level the meanings and motivations supporting people's behaviors (Anastas, 1999). In addition, quantitative research style tends to be more focused on measuring objective facts while qualitative research style tends to be more focused on constructing social reality and finding cultural meanings (Neuman, 2000). The study exploration implies an inductive process in which most variables are previously unknown but unfold during the research.

A significant weakness of the study's qualitative design relates to the role played by the researcher as an active participant in the data collection process. Therefore, his biases may interfere with the research process to the point of making it spurious. To

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counter this risk, the researcher engaged another clinician a co-facilitator for the initial focus group and another as a professional peer to debrief throughout the research process. He also used triangulation for data analysis: the researcher asked two peers to independently index code and categorize the data to assure that there was coincidence in their conclusions. The differences between the conclusions of the researcher and his peers were discussed and changes were made.

The research design utilized qualitative data. The data consisted of the reflections provided by mental health clinicians who met the sample inclusion criteria. Data was collected through a series of structured focus groups.

Sampling Frame and Recruitment

Participants included in the focus group sample met the following criteria: bilingual Latino therapists, practicing in the Chicago metropolitan area, with at least five years of experience providing services to Latino clients in the disciplines of social work, psychology, or counseling. It was designed to recruit no less than twenty and no more than twenty four providers to fill four focus groups of between five and seven clinicians each.

Non-random, purposive sampling method was initially used to draw from the membership of professional organizations or institutional affiliations. Since this method did not yield the minimum expected sample number, a *snowball or chain sampling* strategy was used.

This study used a non-random, purposive sample since intended to meet pre-set sample inclusion criteria. The study purpose was not to generalize to a larger population, but to select rich information allowing in-depth study (Quinn, 1990). Among the several strategies for purposefully selecting information-reach cases, this study attempted to recruit its entire sample using *homogeneous sample.* This strategy is typically used in focus group and involves a group of individuals with similar backgrounds and experiences who may be affected by a common issue (Quinn, 1990). The homogeneity of the sample is secured by confirming that every individual meets the sample criteria.

The initial sample sources were the stand-alone schools of social work and psychology in the Chicago area, such as The Institute of Clinical Social Work, The Chicago School of Professional Psychology; the schools or departments of social work, psychology, and counseling housed in the main universities in the Chicago metropolitan area such as Loyola University Chicago, The University of Chicago, the University of Illinois, DePaul University, Northeastern Illinois University, Aurora University, St. Augustine College; professional organizations such as the National Association of Social Workers—Illinois chapter and its Diversity Committee, the Illinois Society of Clinical Social Work, the American Psychology Association—Illinois chapter, the Chicago Institute for Psychoanalysis, the Illinois Mental Health Counselors Association, the National Council of La Raza, the Latino Coalition for Prevention, the Latino Social Work

Organization; and the online professional services site Psychologytoday.com.

Psychologytoday.com contains an open-to-the-public database of mental health

professionals with information about the specific profession of those professionals, their

years of experience, professional license, and contact information. Therefore, it

enabled the identification of possible candidates to participate in the focus groups.

Every institution and professional organization already mentioned as an initial

sample source was e-mailed the "Request for collaborating on a research project"

(Appendix E) and attached to it the "Consent form for focus groups" (Appendix D). Once

the Institution agreeded to cooperate, it forwarded the e-mail with its attachment (1) to

all members of the Institution/Organization and asked those interested in participating

to contact the researcher or (2) to those individuals who possibly met the study sample

criteria and asked those interested in participating to contact the researcher. The

"Request for collaborating on a research project" provided the title and purpose of the

research project, indicating it was a dissertation study by a student pursuing a Ph.D. in

clinical social work at Loyola University Chicago. It also included the name and contact

information of the researcher, faculty sponsor and the Compliance manager at Loyola's

Office of Research Services. Once the researcher was contacted by those interested in

participating in the study, he e-mailed to the individual an "Invitation to participate on a

research project-referral" (Appendix G).

In regards to online professional services, the public data base

Psychologytoday.com, was used by the researcher to conduct a search aimed at finding

individuals who met the study sample criteria. An e-mail, based on the contact

information posted by the professional, was sent to each of those individuals asking for

their participation in the project (Appendix F). The e-mail provided the title and purpose

of the research project, indicating it was a dissertation study by a student pursuing a

Ph.D. in clinical social work at Loyola University Chicago. It also included the name and

contact information of the researcher, faculty sponsor and the Compliance manager at

Loyola's Office of Research Services. In order to provide more comprehensive and

detailed information, a blank consent form (Appendix D) was attached to the e-mail.

Since the homogeneous sample strategy did not obtain the minimum expected

sample number, a *snowball or chain sampling* strategy was used in the second phase of

recruitment. To this end, individuals already recruited were asked to identify other

therapists who possibly met the study sample criteria, share with those potential

participants a blank form of the "Consent form for focus groups" (Appendix D), and ask

them to contact the researcher if interested in participating. Once the researcher had

been contacted, he sent to the referred individual an "Invitation to participate on a

research project-referral" (Appendix G).

The criteria for the sample were determined according to several factors. The

main reason to select Latino clinicians who were bilingual was based on some of the

findings in the literature review conducted for this study. Great emphasis has been

given in that literature to the need for providing culturally-sensitive services by

culturally-responsive providers in order to address and overcome culturally-related

issues, such as stigma, brought to the therapeutic encounter by clients. Ultimately, the

decision in regards to the sample was made taking into account that common ethnicity

and language have been mentioned by Latinos as factors which may facilitate their

perception of the clinician, at least at the beginning of psychotherapy, as a more

culturally-sensitive individual (Sirey, 1999; Choi & Gonzalez, 2005; Ojeda & McGuire,

2006; Grote et al., 2007; Shattell et al., 2008). Despite this decision and based on his

own experiences, it is recognized by this researcher that Latino clinicians can be less

culturally-responsive to their Latinos clients than clinicians from other ethnicities. It is

also possible that cultural similarity may lead to a "blind spot" in the therapeutic

encounter, which may make it more difficult for the clinician to provide culturally-

sensitive services.

There are many Latinos whose first language is English. Latinos are a very

diverse population in the U.S., with different levels of acculturation which may affect

their adherence to Latino cultural values and therefore the impact some culturally-

related issues, such as stigma, may have upon them. Hence, the sample was inclusive of

clinicians who were bilingual and provided services to Latinos other than those

monolingual Spanish-speakers and/or those with lower levels of acculturation.

The requirement for the sample group members to have at least five years of experience might be considered capricious by some. This decision was made based on common wisdom which assigns that period of time as the minimum to consider a clinician "experienced."

The choice of the disciplines of social work, psychology and counseling for a mental health provider for inclusion in the sample was related to the legal, professional certification of these professions which guarantee a minimum level of competency. The requisite of being a practitioner in the Chicago metropolitan area was related to feasibility, considering that the data was going to be collected using focus groups, with the clinicians physically present rather than virtually present through online focus groups.

Sample Size

The size of the sample is a controversial, ambiguous issue for qualitative studies in general, and for focus groups in particular. A number of judgments must be made regarding the total sample size, the number of participants in each group, recruitment of sufficient participants to address attrition and the length of time allowed for the focus group. Four focus groups, one-and-a-half-hour in duration, with five participants in each was the goal for this study. The rationale for decisions regarding the participant size, number and duration of the focus groups for this study was based on research literature which is summarized below.

Sampling to the point of redundancy is the ideal in qualitative studies (Quinn, 1990). It is based on the concept of diminishing returns according to which "if new and unexpected insights continued to be generated from new people contacted, there is a need to continue to include additional respondents and/or to gather more data until predictable patterns can be articulated and confirmed" (Anastas, 1999, p. 292). However, this ideal is almost impossible to reach in practice because of limited time lines and constrained resources in research projects (Quinn, 1990). A general principle in order to determine an adequate sample size in qualitative research is to choose a number which is not too large to prevent doing a deep analysis of it and not too small to prevent a new, rich understanding of the phenomena under analysis to emerge (Sandelowski, 1995). Patten (2000) suggests for qualitative research proposing an initial sample with one to twenty participants. She arrives at this suggestion after offering some practical considerations that bear on sample size: examining the typical sample size in studies similar to the one being proposed, considering the resources available to the researcher, particularly funds, asking experienced researchers for their advice, and keeping in mind that compelling research questions may be approved even with small samples (Patten, 2000).

In regards to focus groups, there seems to be consensus that the ideal number is to have between six and ten participants per group. Fern (2001) mentions as ideal "8 people, give or take 2" (p. 161). Bloor (2001) advises "groups consisting of between six

and eight participants as the optimum size for focus group discussion" (p. 26). At the

same time, there are reports of focus groups ranging in size from two to fourteen

individuals. Both small and large focus groups have advantages and disadvantages

(Bloor, Frankland, Thomas, & Robson, 2001). Those advocating for large groups

indicate that more people can provide more information and note that small groups can

potentially result in limited discussion (i.e. by the presence of shy or reticent

participants), and are at risk of cancellation if just one or two participants do not show

up. Large groups, however, can also present difficulties. They can be more difficult to

moderate and may be frustrating for participants if they feel they did not have the time

to express their opinions. When participants are very eager to join in the discussion,

large groups can turn into chaos. The more outgoing and vociferous members may take

over and finally only a small portion of those present contribute to the discussion. Small

groups may be advantageous when 1) dealing with experts or people in authority who

might respond negatively if they feel they did not have enough time to express their

opinions, 2) the outcome of the group is expected to come mostly from the discussion

among members rather than from their individual opinions, and 3) the interest is in the

unique expectations of specific segments. In all of these cases, "smaller groups of four

or five make more sense" (Fern, 2001, p. 161).

In this study, the sample was formed by similar, experienced mental health

professionals who were expected to be talkative, engaging group members eager to

share their views and opinions. Those who decided to attend the focus group had a common interest and unique expectations in regards to the topic of stigma as a barrier for Latinos to remain in psychotherapy. It was the synergy coming from the group dynamic which was expected to provide most of the richness to the data. Therefore, the three above-mentioned characteristics in which groups of four or five people are potentially more advantageous were present in this study.

Additionally, the number of participants in the group has significant implications for the transcriptions of recordings—in terms of assignation of identifiers, time and cost. As Bloor (2001) states, "focus groups are labour intensive in recruitment, transcription and analysis, therefore, where possible, number should be kept down to the bare minimum" (p. 28). Taking into account the expressed reasons, small focus groups formed by four or five individuals seemed to be ideal for the proposed study.

In regards to the number of focus groups to be conducted, Fern (2001, p. 162) cites a robust literature which concludes that for exploratory tasks, "fewer than five groups is probably adequate." This conclusion is based on Churchill's (1992) elaboration on this issue. According to Churchill (p.6), "from the first interview on an unfamiliar topic, the analyst invariably learns a great deal. The second interview produces much more, but not all of it is new. Usually by the third session, and certainly by the fourth, most of what is said has been said several times, and it is obvious that little is to be gained from continuing." Then, in the case of the proposed study, four focus group

session were expected to be conducted, each one with different participants. Reconvening the same participants did not seem practical or suitable for an exploratory research which was not looking for segmented data. Concerning the duration of each focus group, one-and-one-half hours seemed the ideal length of time taking into account the courtesy due to busy professionals who were volunteering their time to attend the meeting and the need to accomplish the focus group goals (Bloor et al., 2001).

In conclusion, four focus groups with a one-and-a-half-hour duration and five participants each was the goal for this study. To address possible attrition and since every participant was expected to attend only one focus group, this study attempted to recruit twenty four clinicians for the four planned focus groups. A total of twenty clinicians were expected to be the final sample. This number was consistent with the number of participants mentioned by Patten (2000) for qualitative studies. The number was also consistent with one qualitative, exploratory study which used a sample of clinicians attending focus groups. Choi & Gonzalez (2005) had a total sample of eighteen clinicians who attended three focus groups. Their study, very similar to the one described here, was focused on geriatric mental health clinicians' perceptions of barriers and contributors to retention of older minorities in treatment.

Data Collection

Data was collected through focus groups using a semi-structured interview format including a series of guiding questions (Appendix C) and case vignettes (Appendices A, B). Responses were audiotape-recorded and subsequently transcribed for analysis.

In general, focus groups are considered particularly well-suited for exploratory studies (Neuman, 2000). Among their advantages, it has been noted that they produce rich, flexible data. They are praised for being "stimulating to respondents, recall aiding, and cumulative and elaborative, over and above individual responses" (Fontana & Frey, 1994, p. 365). In this particular study, those advantages facilitated to explore the underlying conceptual understanding of the researcher according to which clinicians seldom purposely address the issue of social stigma once the therapeutic encounter has begun, though they sometimes unconsciously may use ways to overcome it. It was expected that because focus group members react not only to the questions and materials (in this case, case vignettes) suggested by the researcher but also to each other's comments, the group process would result in more revealing responses than a series of individual interviews (Anastas, 1999).

Three additional aspects related to focus groups received particular attention: the research setting, the moderator, and the group process (Fern, 2001; Bloor et al., 2001). The main consideration in the choice of venue must be its impact on the

recruitment process and therefore attention to accessibility is paramount (Bloor et al.,

2001, p. 56). In the proposed study, the venue was a determinant factor in the focus

groups composition. Three places were offered for the participants to choose the one

more convenient for them. Since four focus groups were expected to be conducted,

one place was planned to be used twice. Once a participant was recruited, she/he was

informed of the dates and places where each focus group would take place. It means

that potential participants choose based on date and location. Every potential

participant was asked to rank the options from 1(the most desirable) to 4 (the least

desirable) accordingly with her/his preference. The potential participant was informed

that her/his first choice would be honored when possible, but that it could not be

guaranteed. The available spaces were filled in advance on the basis of "first come, first

serve," taking into consideration the communication of choice made for each

participant's convenience. The focus groups were expected to take place once a week

each during four consecutive weeks. These were the locations which were planned to

be offered: the researcher's agency office in the Pilsen-Little Village neighborhood, a

mostly Latino Chicago neighborhood where many Latino mental health providers work

and/or live; the private practice office of the focus groups co-facilitator in Oak Park, a

suburb in the southwest part of Chicago close to the Latino neighborhoods of Berwyn

and Cicero; finally, the researcher's private practice office in the north side of Chicago, a

venue in a part of the city where many mental health providers are located.

Privacy is another major concern when making plans about the setting in which focus groups will take place. All three places offered enough privacy in order to maintain a confidential meeting. Nevertheless, a sound screen was placed outside the room where the focus group was being held to reinforce confidentiality.

The researcher facilitated all of the focus groups. One or more focus groups was expected to be co-facilitated by the researcher and a bilingual, highly regarded, Latina clinical social worker with a Ph.D. in clinical social work and many years of experience, not only in private practice as individuals, couples and group therapist but also as a consultant, professor, researcher and board member of many organizations working with the Latino community. During the focus groups, the co-facilitator participated with the researcher in presenting the case vignette, asking questions, stimulating discussion, and guiding the debriefing segment at the end of every group session. Once the group ended, the co-facilitator and the researcher would meet to debrief, evaluate and plan the next group session.

The focus group co-facilitator and the researcher have a strong relationship as she was his preceptor for the clinical practicum in the Ph.D. program and was the clinical external consultant for a mental health program overseen by the researcher in the past. Therefore, they were mutually aware of their biases, strengths and weaknesses and were expected to help each other to stay on track during the data gathering process

providing an additional safeguard to this process. This was the main reason leading the researcher to choose her to co-facilitate the focus groups.

It is important to mention that both the researcher and the focus groups co-facilitator are Latinos, as well as the group participants. According to the literature, when the moderator and the focus group members are of the same racial or ethnic group, not only greater rapport and increased respondents' willingness to participate is expected but it will "contribute to increased reliability and validity of the information collected" (Fern, 2001, p. 78).

In regards to the group process, it is pertinent to mention issues related to self-disclosure and social influence (Fern, 2001). Self-disclosure involves making oneself known to others by verbally disclosing personal information (Chelune, 1978). Even though experienced clinicians are expected to have the knowledge, awareness, and practice in handling confidentiality, the risk that confidential information they possess about their clients might be shared during the focus group discussions is a matter of ethical concern. This was a real risk in the study because the topic of discussion revolved precisely around the personal experiences clinicians attending the groups had with their clients. To address this concern, in every step of the research process—invitation to participate, consent forms, before starting and during every focus group session—the sample clinicians were reminded of their ethical obligation to maintain confidentiality of specific information which could allow the identification of their

clients. The focus group co-facilitator signed a confidentiality agreement with the researcher (Appendix I).

Another aspect related to self-disclosure which was a matter of concern referred to the level of distress the sample clinicians might experience as a result of their reflecting upon the way in which they had handled and/or were handling particular cases. Even though the process of reflecting upon cases and dealing with some level of stress as a result of it is a normal life event among clinicians, to prevent this to become an issue, some minutes at the end of every focus group session were devoted to debriefing among participants. The participant clinicians were also encouraged to consult with their clinical supervisors, peers and eventually discuss in their own psychotherapy those feelings and thoughts stirred up by their participation in the focus group session. It is important to highlight that it does not mean participants were encouraged to share with non-participants the focus group content. On the contrary, they were strongly reminded of their commitment to confidentiality. However, the researcher could not guarantee to participants that all of them would honor this commitment.

As part of the group process, social influence is frequently considered a factor impeding or making more difficult group discussions. According to Fern (2001), three types of social influence appear to be relevant to focus groups: evaluation apprehension, self-awareness, and normative influence.

Evaluation apprehension refers to the fear of being negatively evaluated by others (Churchill, 1992). The risk is that this factor may lead to decreased participation and generate fewer ideas in the group. According to common wisdom, this seems to be more of an issue when professional peers constitute the group. There is no data to support this belief in regards to focus groups. Nevertheless, the possibility of evaluation apprehension becoming a negative factor in this study was addressed by the focus group co-facilitators, before and during every session, emphasizing the exploratory nature of the study and instructing participants "we want as many ideas as possible, and don't prejudge your ideas" (Fern, 2000, p. 107).

Enhanced self-awareness, which is uncomfortable, may result among other things from the presence of other people, certain surroundings and minority status. In this study, tape recorders were used to record every session. Little is known about the effects of such devices on the self-awareness and consequent behavior of focus group participants. However, since the proposed study had professional practice implications, the participants might be uncomfortable around such devices. This study addressed this potential issue using some high-quality audio-recording equipment placed out of the immediate view of the participants without sacrificing the recording quality. Regardless, participants were previously informed of the use of the audio-recording equipment and had provided informed, documented consent to be audio-recorded.

In this study, a semi-structured interview format, utilizing a series of guiding questions and case vignettes was used to gather the data. There are significant differences between focus groups and group interviews. In the latter, the motivation is usually a matter of convenience and/or economy. The goal is to elicit the group's answers to a sequence of pre-determined questions, as if the interviewer were asking them to a single person. In focus groups, the objective is to elicit, stimulate discussion and thereby understand through subsequent analysis the meanings underlying the responses. In group interviews, the interviewer seeks answers. In focus groups, the facilitator seeks group interaction. Therefore, the "questions" posed by the focus group facilitator are in reality a *focusing exercise* aimed at concentrating the group's attention and interaction on a particular topic (Bloor, 2001, p. 43). The exercise need not, and frequently does not, take the form of a question. Instead, the group may be asked to perform a specific task, hence the name *focusing exercise*.

In this study, two forms of *focusing exercises* were used: vignettes and open-ended questions related to them (Appendices A, B, and C). Vignettes are hypothetical cases reflective of real-life situations familiar to participants and suggestive of the issue matter of exploration. They were prepared by the researcher and evaluated by the focus groups co-facilitator and another experienced clinician to determine their suitability and adequacy. Since it was expected to have four focus groups, two vignettes

were prepared to be used each twice. Taking into account the dynamic of the focus

groups, only one vignette was discussed per session.

Data Transcription

Focus group data can be chaotic and overwhelming in quantity (a 90-minute

focus group may take 8 hours to transcribe and generate more than 100 pages of text)

(Bloor et al., 2001, pp. 58, 59). The process of finding a person with experience in

transcribing focus group data was crucial. An outside individual with previous

experience was hired for doing it. The transcriber signed a confidentiality agreement

(Appendix H). This person had the responsibility to transcribe *all* recorded speech which

includes *all* speakers, even when more than one is speaking, and *all* forms of speech

such as "um" and "aha" expressions. The memory of the facilitator and the researcher,

and the notes taken by the researcher during the sessions were used to clear up any

uncertainties in what was said. It is necessary, as much as possible, to identify the

speakers. In this study, they were identified by number. To that end, every group

member was assigned a tag which remained on display during the session with a visible

number on it. At the beginning of every session every group member was asked to

introduce herself/himself using the assigned number instead of her/his name. This was

recorded and provided a reference point for transcription. The group facilitator

addressed group members by number. In addition, the note-taking researcher assumed

as one of his responsibilities to follow the sequence of participants' interactions and to

register in his notes the identity of the speakers by the number assigned to every participant. Once transcribed, the data was analyzed.

Data Analysis

The primary purpose of data analysis for the qualitative phase is to "identify common themes in people's descriptions of their experiences" (Leedy & Ormrod, 2005, p. 140). The process of data analysis is essentially a synthetic one. The interaction among members makes the data collected in focus groups distinctive from other qualitative methods. As a result of the group members' interactions, some constructions emerge. The data analysis is aimed at reconstructing those constructions into meaningful wholes. Thus, data analysis is not a matter of data reduction but of induction (Lincoln & Guba, 1985).

A necessary previous step to data analysis consists of reviewing the transcripts for accuracy. The researcher listened to the audio- tapes on several occasions and compared them with the transcripts in order to verify that everything said had being captured and that there was consistency between what the participants had said and what had been transcribed. To this end, the researcher used his knowledge of Spanish—which was used sometimes during the sessions by participants—and the notes taken during the focus group sessions. As a result, some changes were made to the original transcripts. The final reviewed version of the transcripts was used for data analysis.

The specific method of data analysis used was the constant comparison method using a grounded theory perspective (Glasser & Strauss, 1967). From the grounded theory perspective, key themes are revealed through the coding process; they emerge from the relationships among the study data rather than being imposed by the researcher's theoretical framework or expected findings (Propp, Apker, Zabava, Wallace, Serbenski, & Hofmeister, 2010).

The constant comparison method is understood as one in which the researcher (1) looks for key issues or recurrent events which become categories for focus; (2) puts together data which provides variations within the same category for focus; (3) describes the categories for focus, including all the variations within it while continually searching for new variations; (4) continues working with the data as to find emerging models and basic relationships (Glaser, 1978; Denzin & Lincoln, 2003; Grinnell & Unrau, 2005; Marshall & Rossman, 2006). When using the constant comparison method, researchers engage in ongoing discovery, seeking to define, understand, and organize categories, as well as to integrate categories and their properties (Propp, et.al, 2010). Categories are constantly compared, revised, expanded, and reduced until they become "theoretically saturated" and new information adds little or no conceptual development (Glaser & Strauss, 1967). It is a process of continuous refinement.

Data analysis is comprised by three steps: indexing, data storage and retrieval, and interpretation (Bloor, 2001). The researcher asked two peers to index code and

categorize the data to assure that there was coincidence in their conclusions. The

differences between the conclusions of the researcher and his peers were discussed and

changes were made to obtain a unified coding. The software package NVivo was used

as an auxiliary for these processes. Even though the researcher had no prior experience

with NVivo, it seemed that Inter-rater reliability was easily tested and seen in the

software program. Indexing is aimed at making the data manageable for interpretation.

In order to index the data, open, axial, and selective coding was used in a cyclical,

simultaneous manner. In the open-coding stage, the researcher read the transcripts

many times. Once the researcher became familiar with the data, code names (known as

nodes in NVivo) were assigned to words, phrases, or sentences that highlighted any

aspect of the possible impact of social stigma on the therapeutic relationship. Initial

index codes (*nodes*) were broad enough to generate themes, allowing identifying key

concepts. Similar index codes were identified and clustered into categories (known as

trees in NVivo) (Bloor, Frankland, Thomas & Robson, 2001; Trainor & Ezer, 2000).   The

contents of the categories (trees) were compared between and within the three focus

groups. The criteria for initial classification included (a) recurrence—multiple

descriptions with the same meaning, and (b) repetition—use of the same wording

multiple times (Propp, et.al, 2010).

In the axial-coding stage, the categories (trees) were reviewed and refined by

identifying and explaining conditions, actions/ interactions, and consequences

associated with phenomena (Strauss & Corbin, 1998). This stage also involved making

links between categories (trees) and subcategories (nodes) in an effort to achieve

greater conceptual cohesion. It is important to mention that the search for negative

cases enabled the researcher to confirm and develop categories until their saturation.

Categories were saturated when no new and relevant information was found in data.

Both the search for negative cases and saturation refined emergent categories, and

their names and links changed until they fit in the data (De la Cuesta, Carmen, 2005).

At this stage of the process, the search for links in order to present a

comprehensive and cohesive frame turned very difficult. It became clear that the

researcher was not allowing the data to "speak by itself" but rather trying to organize

the codes and categories around the notion of social stigma. Becoming aware of this

situation and allowing the data to emerge lead to a total reorganization of codes and

categories around the notion of engagement instead of around social stigma. It was a

turning point which made possible the identification of one of the most significant and

unexpected findings of the study: that for those Latino clinicians participating in the

study, the impact of social stigma on the therapeutic relationship is inextricably

attached to the engagement of their Latino clients. Examples were selected to reflect

this integrative process and to illustrate categories.

In the selective-coding stage, categories were refined and integrated to form a

greater theoretical scheme (Propp, et.al, 2010). The overarching themes among the

categories allowed the researcher to create a narrative that encompassed the three identified categories and their linkages. The core story that emerged is revealed in the results chapter of this study.

Rigor and Reliability

There are several models to evaluate the value of qualitative research i.e. Leininger, 1985; Kirk & Miller, 1986. This study followed the model of "trustworthiness" for qualitative research initially stated by Guba (1981) and developed by Lincoln & Guba (1985). This model identifies four aspects or criteria of trustworthiness which are relevant to quantitative and qualitative studies and develop different strategies to address them in each type of research. The criterion *truth value* is addressed in qualitative research through credibility and in quantitative research through internal validity. The criterion *applicability* is addressed in qualitative research through transferability and in quantitative research through external validity. The criterion *consistency* is addressed in qualitative research through dependability and in quantitative research through reliability. The criterion *neutrality* is addressed in qualitative research through confirmability and in quantitative research through objectivity.

Truth value asks whether the researcher has established confidence in the truth of the findings for the informants and the context in which the study was undertaken. In qualitative research, credibility occurs when it presents such accurate descriptions or

interpretation of human experience that people who also share that experience would

immediately recognize the descriptions (Sandelowski, 1986). In terms of the strategies

to achieve credibility, Lincoln & Guba (1985) state that the findings and the

interpretations based upon them will be found to be more credible if the researcher is

able to demonstrate a prolonged period of engagement, provide evidence of persistent

observation, and to triangulate the data that are collected. The proposed study

attempted to achieve credibility by having four focus groups with no more than seven

participants each; devoting one-and-a-half hours to each focus group; fostering in the

focus groups an environment of mutual engagement and open participation through

explicit statements made by the group co-facilitators such as "we want as many ideas as

possible and don't prejudge your ideas;" presenting case vignettes to elicit greater

discussion; taking notes during the focus group to capture all the possible data and not

only the recorded words (triangulation of data methods); using peer examination to

discuss the research process and findings with impartial colleagues who had experience

with qualitative methods; using reflexive analysis or reflexivity (Good, Herrera, Good &

Cooper, 1985), which refers to the effect of the researcher's own background,

perception and interests on the qualitative research process. It was expected that a

greater awareness would help to neutralize the researcher's biases and personal

interest in the project results.

Consistency asks whether the findings of a particular inquiry would be repeated if the inquiry were replicated with the same or similar respondents in the same or similar context. Because qualitative research emphasizes the uniqueness of human beings and human experiences, variation rather than identical repetition is sought. Thus, variability is expected and consistency is defined in terms of dependability, which means variability that can be ascribed to previously identified sources. In terms of the strategies to achieve dependability, the proposed study paid particular attention to describe step-by-step the methods used for data gathering, analysis and interpretation, which would make the research auditable. Guba (1981) uses the term *auditable* to describe the possibility for one researcher to follow the decision-making process of another researcher. Additionally, dependability was reached through triangulation and peer examination specifically with Inter-rater reliability.

CHAPTER FOUR

RESULTS

Little is known about the impact social stigma has on the therapeutic

relationship. The real implications of social stigma and the clinician's responsibility in

addressing this issue with clients have been rarely noted. It is the purpose of this study

to explore—from the clinician's perspective—(1) the impact social stigma has on the

therapeutic relationship from the time psychotherapy is initiated, and (2) ways in which

some Latino providers may address it when providing mental health services to their

Latino clients. Furthermore, this study intends to consider the role of clinicians in (1)

addressing social stigma in psychotherapy and (2) identifying strategies for dealing with

this issue. The ultimate aim of this research is to improve mental health service delivery

to the Latino population.

The specific research questions for this study are: (1) What is the impact of social

stigma on the therapeutic relationship? (2) How do clinicians address social stigma in

psychotherapy?

This chapter will provide information about the characteristics of the focus

groups and its participants. It will present the results obtained in regards to the

purposes of the study, reporting the way in which the data was organized in codes and

themes using the software package NVivo. Further elaboration on the collected data

will be provided, quoting some pertinent sayings of the clinicians who participated in

the focus groups from which the data was collected.

Focus Groups and Participant Characteristics

Fourteen bilingual Latino therapists, practicing in the Chicago metropolitan area,

with at least five years of experience providing services to Latino clients in the

disciplines of social work, psychology, or counseling participated in three focus groups.

Most participants were female; most participants were licensed clinical social workers;

and participants were equally divided between US-born and Foreign-born. A more

specific composition of the sample is included in Tables 1 and 2.

Table 1

Participant's Gender Vs Profession

	Social Work	Counseling	Psychology	Total
Female	8	2	1	11
Male	3	0	0	3
Total	11	2	1	14

Table 2

Participant's Gender Vs Place of Birth

	US Born	Foreign Born	Total
Female	6	5	11
Male	1	2	3
Total	7	7	14

The initial sample sources were the stand-alone schools of social work and psychology in the Chicago area, the schools or departments of social work, psychology and counseling housed in the main universities in the Chicago metropolitan area, professional organizations, and the on-line professional service Psychologytoday.com. A total of 38 communications were sent out for recruitment purposes. Two individuals were invited to participate, taking into account the information posted on their profiles in Psychologytoday.com. As a result of these efforts, three individuals were recruited. Since this initial sample recruitment strategy did not obtain the minimum expected sample number, the "snowball" strategy was utilized. The three individuals initially recruited and the new ones recruited through them were asked for referrals and did so. In the end, seventeen clinicians who met the sample criteria were recruited using the *snowball* strategy. Four of them, after expressing initial interest to participate, did not follow up. Two of them confirmed their participation but because of last-minute

emergencies were unable to attend. In the end, the sample included 14 clinicians attending three focus groups.

The goal for the study was to have four focus groups with five participants each. Three focus groups were conducted, two of them with the expected five clinicians and another focus group with one participant short of the minimum initially planned. The fifth person cancelled immediately prior to the focus group starting at a time when it was impossible to replace her. Two factors were pondered to determine having three instead of four focus groups: difficulties in recruiting participants and data redundancy. It was not anticipated that recruiting clinicians who met the sample criteria would be as difficult as it turned out to be. The non-random, purposive sample using the *homogeneous sample* strategy proved to be almost totally ineffective. The use of the *snowball* strategy took much more time and effort than anticipated in terms of requesting several times from the recruited clinicians the referral of new potential participants. At the end of the third focus group the gathered data was evaluated by the researcher and two members of his Dissertation Committee. It was considered very unlikely that new and unexpected insights would continue to be generated from an additional focus group. It became clear that data saturation had occurred and another focus group would yield redundant data. Therefore, three focus groups were considered sufficient.

Two of the focus groups were formed by five clinicians each and the third one

was formed by four clinicians. The initial focus group was co-facilitated by the

researcher and a licensed clinical social worker Latina with a doctoral degree in clinical

social work. The last two focus groups were facilitated exclusively by the researcher.

The focus groups lasted on average ninety minutes each and took place in three

different locations: the researcher's office in the Pilsen-Little Village neighborhood of

Chicago, the co-facilitator's office in downtown Chicago and a social service agency

located in Berwyn, IL. In every case, confidentiality was ensured by using private spaces

and placing sound-screen devices outside the meeting rooms. In the focus groups, a

semi-structured interview format, utilizing a series of guiding questions and case

vignettes, was used to gather the data (Appendices A, B, and C). For the first and the

third focus groups the case vignette titled "Mexican" was utilized (Appendix A). For the

second one the case vignette titled "US-born" was used (Appendix B). The guiding

questions were the same for all focus groups (Appendix C).   In regards to the group

process, the participants were identified using numbers instead of proper names. It did

not seem to disturb the communication exchange among the participants but rather

made it more organized, preventing communication overlaps in which more than one

participant was speaking at the same time.   The participants had excellent mutual

rapport and were engaged in the group process. Issues related to self-disclosure and

social influence were not identified by the facilitators or reported by the group

participants as having a negative impact on the process. On the contrary, a generalized

sense of satisfaction with both the process and the outcome was expressed by the

participants at the end of each focus group.

Coding Process

The audiotape-recorded data from the focus groups was transcribed by an

individual with previous experience transcribing focus group data and electronically

returned to the researcher.   The transcribed data was reviewed for accuracy and some

minor adjustments were made by the researcher, particularly when participants used

expressions in Spanish. Once the transcribed data was reviewed, the audiotapes were

destroyed.

The reviewed, transcribed data was imported into the computer-assisted

qualitative data analysis software package NVivo. A password-protected Loyola

computer was used to store the electronic files. After several readings of the data, a

first-level of data organization took place. The data was organized into coding

categories (referred to as "nodes" in NVivo) utilizing the constant comparison method

(Denzin & Lincoln, 2003; Grinnell & Unrau, 2005; Marshall and Rossman, 2006). Twenty-

two nodes were created by the researcher and used for a second-level coding consisting

of organizing the nodes into themes (referred as "trees" in NVivo).   Two colleagues, one

of them a Ph.D. and the other a Ph.D. candidate, were asked to code the data into

nodes and trees. Their way of organizing the data was compared with the one used by

the researcher. Based on this comparison and with the colleagues' feed-back, some

revisions were made and an agreement was reached. Finally, seventeen nodes and

three trees emerged from the data. The trees and the nodes organized into each as well

as the number of sources—meaning the number of focus groups in which the topic

under the specific category was mentioned—and references—meaning the total

number of citations related to the topic occurred—are listed in Table 3.

The researcher expected that social stigma would be seen by participants as an

independent factor impacting in a significant way the therapeutic process. Initially, the

researcher intended to organize the data based on this assumption. However, as it will

be discussed later, this expectation was not confirmed by the data. Rather, participants

saw social stigma as inextricably linked to the engagement process. Furthermore, social

stigma was perceived as one among many factors to be considered when engaging

clients in therapy. It was not seen as unique to the therapeutic process as expected by

the researcher. This finding became clear and was reflected in the final way in which

the data was organized. It forced the researcher to change his initial approach and

allow the data "to speak for itself."

Table 3

Trees and Nodes

NAME	CODE	# of SOURCES	# of REFERENCES
ENGAGEMENT RISK/ FACILITATING FACTORS			
Clinician Culture	ClinCult	3	27
Stigma Gender	StigGender	3	10
Stigma Involuntary Client	StigInvoluntClnt	3	13
Stigma Mental Health System	StigMHSystem	2	7
Client Socio-Economic Status	ClntSES	3	9
Social Stigma	SocialStig	3	19
Stigma Duration	StigDuration	2	3
ADDRESSING RISK/ FACILITATING FACTORS			
Clinician Role Engagement	ClinRoleEng	3	6
Empathy	Empathy	3	7
Environment	Envrnmt	3	13
Normalizing	Norm	3	9
Strengths	Strngths	3	6
Stigma Psychoeducation	StigPsyched	3	29
Clinician Role Boundaries	ClinRoleBoun	3	33
Groups	Grps	3	14

Table 3: Trees and Nodes (continued)

THERAPY DROPOUT FACTORS			
General Dropout Factors	GenDropoFact	3	8
Stigma Dropout Factors	StigDropoFact	3	13

Data Results

Three trees were identified from the collected data: Engagement Risk/Facilitating Factors, Addressing Risk/Facilitating Factors, and Therapy Dropout Factors. Data from each of them is presented below.

Engagement Risk/Facilitating Factors

Seven nodes were organized under this tree as factors which may facilitate or prevent the engagement process to successfully occur: clinician culture (ClinCult), stigma gender (StigGender), stigma involuntary client (StigInvoluntClnt), stigma mental health system (StigMHSystem), client socio-economic status (ClntSES), social stigma (SocialStig), and stigma duration (StigDuration).

The node **"clinician culture"** refers to how coming to and remaining in therapy may be influenced by the culture of the clinician. In this particular study, it refers to the influence that having a Latino clinician or a clinician from a different culture may have for Latino clients. For participants, this influence may start even before the first therapy session:

I agree in the fact it is an advantage, especially before a client walks into the door, recognizing that you have a Latino name. And there is a certain comfort in having a Latino or Latina counselor."

Culture encompasses a variety of factors, and in some cases even including physical characteristics. As one participant stated:

Being Latina in itself does make a difference. I think just looking the same way they see someone that has kind of the same color hair or the eyes—that does make a difference. It provides that comfort just coming in.

When client and clinician come from the same country, this was reported as significant for participants:

Whenever I'm working with a Latina client, I feel connected with her already and I also see this happening to her when she asks: Where are you from? And I say, well, I'm from Mexico. It's like you see this spark in their eyes—do you remember this, do you eat this, do you do that, do you know this place—there is an exchange to find this common ground.

At the same time, participants recognized that client(s) and clinician may come from different ethnic groups within the Latino culture and that this difference is noticed in the therapeutic encounter:

They are actually very forgiving even if they see that you are bi-cultural, that you might be not exactly from the specific ethnic group that they are from. For example: the group that I have been facilitating for ten years now is formed primarily by Mexican men and women. And so I go into it with an attitude or spirit of learning. I'm Cuban, I'm bi-cultural. They very much will share because you are part of at least the Latino universe. They, I think, come in with an acceptance or an assumption that you at least embrace the more universal core Hispanic values.

Participants mentioned language as a significant component of the culture and stated that it impacts the therapeutic encounter:

The language piece I think is huge. That they can say a word and you know what they mean and you know whatever that means in the culture, that you get it, it is huge. And so I think again that it goes against the stigma.

Participants elaborated on the language piece when their clients were not monolingual Spanish-speaking individuals:

There are some families who need you to speak Spanish and other families, they need you to go back and forth because they go back and forth between English and Spanish and then you need to pay attention to when they switch.

Some other participants emphasized the reason for being attentive to the alternative use by clients of English and Spanish in the same therapy session:

The other piece I wanted to mention was the language. When they want to switch from English to Spanish, the meaning, what is behind that…because most of the time they are trying to send us a message. Or it is even more meaningful when they are switching it to Spanish and you have to be aware…because there is a purpose for it.

Some participants highlighted what they perceived as the negative impact on the engagement process from having a "white" clinician:

I saw a white therapist, and I also went later to a Latino therapist, and being on the other side of the couch, I saw the differences in the engagement, in the conversation, that those differences were very marked. And I was very much turned off by my white therapist because of the style and the rest being that I was born here, acculturated to some extent, it was still difficult for me, so even more, I put myself in the shoes of the less acculturated immigrants that we typically serve.

Some other participants emphasized the fact that therapeutic services may be provided beyond cultural differences:

But I also agree that it does not necessarily mean it does not allow for a clinician from a different culture to practice as long as the person is culture confident.

And I would also add as long as they recognize from the start the differences between client and clinician.

Some specific examples to reinforce this idea were provided:

We actually have a lot of therapists at (name of the agency) that are bilingual but not bi-cultural and I have to say that I'm very impressed with how much they know about culture even if they are not bi-cultural. At least the ones that we work with directly, they really have embraced the culture in doing the work.

The possibility of Latino clinicians not providing culturally-sound services to their Latino clients was also recognized:

When you are from the culture you can make the connection, meaning of family, meaning of the community, there is something there because you are from the culture—not that you cannot learn it and experience it coming from outside the culture—you can be a Latino therapist and you do not get it, or if you come from a kind of traditional Anglo kind of ethnocentric, it will not work.

The node **"stigma gender"** refers to how the gender of clients and clinicians may influence the engagement process and the issue of stigma in therapy. Overall, participants reported that females tend to be the majority of their clients in therapy. Participants did not perceive this fact as exclusive among Latinos:

If I look at my caseload which is mixed—not only Latino—it is mostly women who come to therapy. And I think it is a similar issue for males; they are less likely to go, to establish this relationship and to talk about their issues. And it may be more pronounced in our culture, but I see it in the Anglo culture also.

The issue of gender as related to stigma was mentioned: "I think there is less stigma if it is the woman, the Latina woman in the family who goes to therapy."

When both parties in the therapeutic dyad were males or females, it was seen as

a facilitating factor for establishing a good relationship in therapy:

> Any time you can identify with the therapist on any level, gender and ethnicity, it
> helps to establish rapport.
> Furthermore, I happen to be male. I tend to have a lot of male clients,
> too, because Latino men will look for a Latino male.

On the other hand, when client and clinician were not of the same gender, it was

seen as a risk factor for establishing a good relationship in therapy:

> But it is a constant struggle, especially if you are a male working with a female
> Latina client, or if you are a female working with a male. It is a challenge and I
> know it because I also supervise and know some of my female supervisees
> sometimes struggle with the way some of their Latino male clients approach
> them. And they do not know how to channel the work at that. And it is a
> learning process, it is not something you can learn in a book or in theory, you
> have to experience it.

More specifically, it was said, "I do believe that Latino males take longer to get

engaged if a woman is the therapist."

However, the difficulties coming from gender differences were also seen as

positive opportunities:

> It goes well for Latino males serving Latina women to put on the table from the
> start that "Well, yes, I am a man," and how that plays into the dynamic and
> addressing that issue also increases engagement and comfort especially when
> there is a lot of preconception of the male role in the culture of machismo and
> the rest could be very beneficial.

The link between social stigma and gender differences in therapy was explicitly

recognized:

But one of the fears they have is that if they have a wife she is going to be jealous. And I have dealt with that. And that is the one thing that I wrote down here that is stigma—that I think is stigma as well within the family.

The node **"stigma involuntary client"** refers to the possible stigmatizing effect of going to therapy because of others' initiative or pressure and how it affects the engagement process. Involuntary clients are understood as those who perceive their going to therapy not as a result of their own initiative but because they feel they have to do it because they want to please others or because they feel being forced, pressured or mandated by others.

Involuntary clients were described by participants as being ambivalent in regards to therapy: "They come to see what it is going to be like and to see if 'I'm going to stay, if I want to engage.'"

Involuntary clients were sometimes perceived as being difficult to deal with:

They do not really know why they are there except that they are forced to be there and when you are working with a client who has very little insight into his own behavior, attitudes and reason for getting counseling in a way you get involved in multiple conversations at the same time, "my wife said, my probation officer said." It is always about to what someone else said.

Furthermore, a possible connection between being an involuntary client and shame was stated:

I also talk about the shame that sometimes comes with taking this step (going to therapy). I think in this vignette with the Latino client who is there because his wife sent him, I think that would have to be addressed.

The referral source was perceived as possibly having a positive influence on the engagement process though participants expressed different perceptions about the effects of it on remaining in therapy. One participant stated:

> I would say that in my experience it does not necessarily influence so much the length that they will stay in therapy, but definitely the likelihood if they will follow up. So, that trusted relationship (between the client and the referral source) would increase the likelihood that they would say, "Okay, well, if you referred me, I will follow up."

Another participant presented a different opinion:

> I am going to assume that the priest she spoke to is someone she had a relationship with and perhaps she was going to that church on a regular basis. And if he was a trusted person, the fact that he referred, I think it would perhaps influence her disclosure in the first session and would give me the sense that she would come back because of trusting the referral source.

Participants viewed the different implications of being an involuntary client as a general phenomenon rather than something exclusive to Latino clients: "But I would not; I do not think this is something specific to Latino clients. I might say that might be more general."

The node **"stigma mental health system"** refers to the impact that the possible stigma associated with being involved with the mental health system, i.e., government entities, insurance companies and diagnosis may have on remaining or leaving therapy.

According to participants, using insurance can be problematic for clients: "When they have to use insurance, they will do it in the end because they will either use it or cannot afford to come. But it is always an issue."

Though, according to other participants, this is not always the case:

> My experience has been that they are happy that they have access to this (the insurance), that their job provides it or helps them because otherwise they could not do it. So I have had no issues with that.

According to participants, the issue of using or not insurance for their clients is

related to the diagnosis, which needs to be made for a reimbursement to occur, and the

eventually negative future consequences in clients' lives:

> We have to explain to them the consequences of certain diagnosis. So they can be informed really of what they are doing when they access their insurance and its benefits. And the truth is that even if they are receiving mild diagnosis, because of the way the health care system is, it can have very negative consequences for them in the future.

Sometimes, the issue reported by participants was not related to the use of

insurance but to the association their Latino clients can make between the provider and

a feared government entity:

> We get confused with DCFS (Department of Children and Families of the State of Illinois), especially for Latino families. They are scared that we work for the state, that somehow we are connected to immigration, that you know, we are asking too many questions. There is a piece of it, especially if they have had any threats from DCFS, or any kind of past experiences. But I think that is part of the relationship, that at the beginning you have to work really hard with them to convince them that you are there to help them to stay out of DCFS or some other systems. They do not understand the systems and they just see you as an authority that is related to something that could get them in trouble whether it is immigration or DCFS and so.

The node **"client socio-economic status"** refers to the characteristics of those

Latinos with whom participant clinicians have or have had therapeutic relationships and

mostly through whom, the researcher assumes, they have shaped the perceptions those

clinicians shared in the focus groups. All clinicians reported having in their caseload mostly, if not exclusively, individuals with similar characteristics: "They are low-income, low-education level, from the fields, from the mountains--mostly females-- very low acculturation."

Most of them *"have documentation issues, many of them are not documented legally."*

The lack of understanding about therapy was consistently mentioned by participants as a typical characteristic of their clients: "They do not really have education, experience, and any idea about what counseling is about."

Nevertheless, some participants reported having experiences with Latinos coming from other backgrounds:

> I have definitely undocumented, poor, working poor, but I have also worked with professionals coming from Latin America—doctors, lawyers, teachers—that somehow when they come here because of their immigration status they have to do the menial work, but they are highly educated people.
> I'm in private practice now, so I get some professionals, some people who work in factories who have insurance and who get referred by their doctor or sometimes their boss. So it is kind of, you know, lower-middle, middle class.

It was recognized that there are different levels of acculturation among Latinos. Some participants stated that the level of acculturation of their clients is a determining factor of the therapeutic relationship:

> There [are] a lot of acculturation differences among Latinos and so in my experience the expectations and mindset of those more acculturated are more mainstream. Therefore, you are going to treat them more similar to other Americanized, versus the way in which you treat the more traditional, less

acculturated people we are talking here. The relationship will look differently depending on the Latinos themselves because of the acculturation factor.

Participants who work with couples pointed out issues related to mixed couples—those in which one spouse is Latino and the other is not, and where immigration status may also be different:

> I work with mixed couples where they are married and one spouse is Anglo and the other is Hispanic. And it is not the thing anymore that you marry an Anglo and you are free. So that has a huge impact on couples with the stress of the spouse who may be sent back. I have seen a lot of couples where there is a difference—often one spouse, often the Hispanic, has a lower level of education; they will be busboys in restaurants or something; the spouse is a teacher or you know, a little upper level and the issues that come up around it are big. And about family—Hispanics who send money to their families in their countries of origin, it is a huge cultural issue because in the Hispanic culture that is a given; that is a given and not so here.

The node **"social stigma"** refers to the different ways in which social stigma is presented or not by clients and/or it becomes evident for participant clinicians with their clients. Participants reported knowing that clients were dealing with social stigma because they were saying it explicitly: "I think a lot of times they will tell you like, 'you know, people think I am crazy' (for being in therapy)."

Or, communicating it implicitly:

> They know they are not crazy, but the stigma is still there and you can tell when they are either saying do not call my house or answering the phone. I have had clients answering their home phone and saying they are somewhere else.

Some other times, participant clinicians perceive social stigma through reading their clients' body language:

I think their body language can tell a lot. They will be like agreeing, but you can tell they are holding back. There is something behind that they might not being agreeing with, but they are being polite—almost a false politeness—almost. It makes me wonder.

Clinicians reported that social stigma about going to and remaining in therapy was primarily associated with being seen as "crazy" but also with being sick and/or weak. As one participant stated:

I think the most important thing I consider when thinking about the impact of social stigma is the feelings clients may experience of being crazy or sick or weak. I guess those are the main things, that somebody is deficient and weak for going to therapy.

For participants, social stigma also may be associated with generation issues:

"My parents are not going to see somebody to get help. I mean it's just not part of their generation to do that even when they are very, very educated."

Social stigma may be associated with the place in which services are provided:

We do office-based, we do home-based, we go to schools—wherever they are at, we are there to meet them. I think sometimes that can make the difference, the setting itself. Maybe it does not feel so like it is stigma "when you are coming to me." I do not know. Or it may—I think it depends on the situation. My experience has been that some parents are okay with me coming to their house, but then I get some parents, they do not even want to talk about it. I mean, you are going into their home and it means like you are addressing them specifically, like they are the problem.

Social stigma maybe associated with shame: "And maybe stigma and shame are related. I think the stigma comes from feeling some shame about needing to go for help."

Social stigma may be associated with guilt when clients disclose at the beginning

of therapy intimate information:

> I am surprise[d] that in the assessment she revealed she had an abortion. In the first session this is typically something very difficult to share and reveal. So she had the confidence in the clinician but I do not know if this would be a case in which she would not return because she feels certain guilt for having revealed that. That she disclosed too much.

> Social stigma maybe associated with fears of betraying the spouse:

> It is not only that you are crazy but that you are going to cheat on me if you go to therapy because you are going to get closer to the therapist, whoever the therapist is, than to me—husband or wife.

> The possible connection between mental illness and social stigma was

acknowledged and discussed by participants. For them, it is rooted in the pervasive

notion of therapy as being for crazy people:

> For Latino families, one thing I think in regards to stigma is that along mental illness and mental health there is such a spectrum. And so this whole idea that if you are going to see a doctor it is okay but if you are going to see a psychologist then you are crazy, it is interesting.

> However, some participants highlighted a different way in which clients perceive

their mental illness or their mental health-related issues as something detached from

the social stigma traditionally linked to it. This change seems to be rooted, according to

the participants, in the Latino cultural value of the non-dualistic connection between

body and emotions:

> I was going to say that I think there is, at least in my experience, there has been an interesting anomaly when it comes to some diagnosis or one area where a family member is identified as going to therapy and everybody is watching this

person go. My experience with the population I work with, which is the less acculturated low-income Latina women, is that they share that, aside from the group, they are seeing someone individually. They are okay saying, "I am seeing someone for my depression." So there is that bridge between the old school and another version of that whether you are Cuban, Puerto Rican, Mexican, Central American, and South American there is that spiritual cognitive connection that "what is going on in my life affects my emotions and my life." So when they say they are seeing someone for their depression, I do not sense and they do not express a discomfort in the sense of stigma. It is validation that I am not crazy. I have been telling it to my husband and now I have a professional—and, of course, we all know the whole deference to credentials, right? Educated people and the value we put on that in the Latino culture—a psychologist or a Ph.D. or a LCSW saying, "I am giving you a diagnosis." You know, depression or life stressor, your Axis five or whatever that is called, but it is related to events in your life and it is a stressor that you are experiencing and this is a depression and we are going to deal with it. And it as a validation for what they know they have been feeling intra-psychically.

There was consensus among participant clinicians in their perception that for

some clients social stigma is not an issue:

What I have also noticed is that not everyone comes in with that stigma. Again, sometimes clients are very aware, very ready and very engaged from the start in the process. They call in seeking services because they know exactly what it is and the value of it and what they want. And that could also speak to how people who have gone through therapy and have promoted it to others really serve at convincing and de-stigmatizing it. So experiencing stigma is not always the case.

One participant provided a particular explanation of why she does not deal with

the issue of social stigma for being in therapy:

I have never had to explore that (social stigma) because I have never seen that as an issue. But I remain open. Perhaps the clients who do not follow through are the ones with whom you need to explore it. And usually, again, as I feel that it becomes a non-issue, it so does not become a focus of therapy. That has been my experience.

The node **"stigma duration"** refers to how long the social stigma associated with being in therapy may remain as a risk factor for the therapeutic process. For most participants, the issue of stigma quickly disappears when a good therapeutic relationship is established. As one participant stated:

> From my experience working with clients, I think that if you establish a successful good connection in the first session, that issue (stigma) disappears very fast. And if you have a client who is consistent and after the first session continues to come, it never comes up as an issue.
> Furthermore, I have some clients who, when they stay longer, will say, "Oh, the reason I am coming here now is because I do not want to be crazy."

However, participants made a distinction when stigma is associated with taking psychiatric medication:

> Stigma tends to disappear. It is true. It is more resistant toward the medication; all the false perception that, "okay, I am doing all right now" so they stop taking the medication without consulting the psychiatrist or so.

For one of the participants, stigma can present at any time in the therapeutic process and clinicians need to be always attentive to it: "I think it (stigma) is an ongoing issue through the therapeutic process. I think we just have to listen to the latent content that is going on and maybe pick it up."

Addressing Risk/Facilitating Factors

Eight nodes were organized under this tree as ways in which those factors facilitating the engagement of clients can be maximized and those risk factors that may prevent the engagement process to successfully occur can be avoided or overcome: clinician role engagement (ClinRoleEng), empathy (Empathy), environment (Envrnmt),

normalizing (Norm), strengths (Strngths), stigma psychoeducation (StigPsyched),

clinician role boundaries (ClinRoleBoun), and groups (Grps).

The node **"clinician role engagement"** refers to what participant clinicians

perceive to be their role in order to engage clients in the therapeutic process. Without

exception, participants mentioned as being the responsibility of the clinicians to engage

their clients in the therapeutic process and to make their best effort to keep them in

therapy. One participant summarized it by saying, "If we really want for her to stay, it is

the role of the clinician to do some work to make sure that she is coming back."

Participants linked the clinician's responsibility to engage their clients to being

aware and sensitive to culturally significant topics. As one participant stated:

> I know for example that I need to be very attentive to the gender roles and
> behaviors attached to them in the culture when I am engaging clients. I do not
> want to be misinterpreted or to put my clients off.

The node **"empathy"** refers to the ability to be attuned and responsive to the

clients' needs, to be "in you[r] client's shoes."

Building empathy was also unanimously mentioned by participants as a key

element to engage clients in therapy. As one participant described it:

> It is more like, "Let's talk about all the things which have happened this year." or
> "Let's talk about how it felt when those things happened." Then, you begin to
> know that empathy is what really builds the relationship on that we are not here
> to judge, we are not here to make assumptions or criticize. Most of the time
> they just need to tell their story to someone.

There were two elements related to "listening to their stories" which were

highlighted by participants as particularly important for building empathy with Latino

clients who are immigrants: exploring their journey to come to this country and

exploring their identities in their countries of origin. As stated by one participant:

> I ask a lot of questions. Many times just the process of coming here is a big piece
> in their lives and they need to know that I do care, that it is not about their
> immigration status but learning about them because you know, my family is also
> a family of immigrants.

Another participant stated:

> One of the things I am always cautious about is, as part of the assessment
> process, to explore what the socio-economic status of the client was in her
> native country, not to see every immigrant as the same. Exploring if she might
> have some professional training, if she is not the typical rural, low-income
> migrant one could think of and to be respectful of that as part of the
> engagement process; so not to turn away the client. Not to make assumptions
> about the client's own identity, but rather exploring her own self-identity as it
> was in her native country.

Empathy as a form of "cheering" was mentioned as being particularly important

at the beginning of therapy. As one participant stated:

> I really encourage them in that first session. I say, "Wow, I understand how
> much courage it took for you to call and I am so glad you came. It seems that
> you are going through a lot and we all need some support at some point."

Attention and responsiveness to sensitive issues, two elements of empathy,

were also consistently mentioned by participants as crucial for engaging and keeping

their clients in therapy. As one participant stated:

> The piece of depression in men and post-partum depression and substance
> abuse in women—I mean all these kind of secrets in Latino families and families

in other cultures, things people do not talk about—then you begin to say, "You know these things did not happen out of the blue. Things, traumas have happened in your life and they may have caused this. Let's connect the dots together." It is like feeling that we are in this together versus you versus us versus you. I think all these things combined especially in the engagement piece are so important for the relationship to continue.

Participants reported being particularly attentive to start the therapeutic process using the same issue used by the referral source i.e., physical health, spirituality to build empathy with their clients. As one participant stated:

My experience with Hispanic clients in particular, is that I have to start with the physical. And when I work with parents, I also start with the physical. I ask, "Have you taken them to the pediatrician, what did the pediatrician say?" I start with the physical because it feels like that is how they ended up at my door, because many of the referrals to me are from their doctors. And there is nothing physically wrong, but they are anxious or they are depressed. So, when I ask they say: "Well, you know, my doctor thought that it would be good for me to talk to you."

The node **"environment"** refers to the need to provide an environment which offers safety to the client and fosters team work between client and clinician. Safety and team work were frequently mentioned by participants as crucial elements in the engagement process. As one participant summarized, "In general, it is about trying to make them feel safer; that they are coming to a safe place and that they will be exploring and learning together, that we are working together."

The node **"normalizing"** refers to the different ways in which participants normalize therapy and how it helps to de-stigmatize the process facilitating it to move

forward. As one participant stated, "I think that we try to normalize what we are doing

with clients trying to make it seem like if it is nothing out of this world."

Normalizing can be achieved using language. One participant stated:

By the time they come to us, they want to tell their story. We hear the narrative
and then it is about educating them about depression or anxiety or panic attacks.
You hear their stories and you say, "well, no wonder why you are feeling this
way. No wonder, you know why you cannot sleep at night" or whatever. You
get to hear the story and then put some words, some language to it, to
normalize it.

It was recognized that being in therapy, especially for Latinos, is anxiety-

provoking and it needs to be acknowledged:

I tend to normalize the person feelings and you know, I think this is more
prevalent in the Latino culture. For any of us, even if we go to therapy
voluntarily, there is anxiety, there is this feeling of talking to a stranger and
opening up personal things.

Self-disclosure was mentioned by participants as being useful to normalize the

therapeutic process. One example of it was sharing the clinician's feelings as a parent:

"I deal with a lot of parenting issues. I think that sometimes parents think they are crazy

because of the way they think about their children or their stress level because of the

situation and then, you know, to normalize it."

A great deal of attention was given to the importance of normalizing the

therapeutic process rather than minimizing its difficulties or the issues around it. As one

participant stated:

We have to be conscious that in normalizing we are not minimizing because I
think we could confuse them (clients) if we say "oh, it is easy, just meet me at

the office" or "I will go to your son's school." And I think the goal is not to minimize their experience of stigma or what they think mental health is, but to emphasize and normalize the experience in a gentle way. But not to minimize it because then you can miss the boat.

The node **"strengths"** refers to the exploration in therapy of the coping

mechanisms and strengths used by clients to deal with their issues. This was pointed

out by participants as one of most valuable strategies to engage their clients in therapy.

As one participant stated:

> Early on, as part of the engagement process, one needs to access the strengths to counter this stigma the person may feel of being weak and crazy for coming to therapy. Instead of pathologizing the client you focus on the strengths. It makes the engagement a lot easier. You challenge the stigma and increase the engagement with the client.

The reasons for the value of this strategy were discussed:

> When you are exploring the strengths the message you are sending is that you are not weak, you are a survivor, you are not a victim and you are a survivor. This is what I can do with you here, but this is possible because you have the skills.

The node **"stigma psychoeducation"** refers to providing education as a way to

engage clients in the therapeutic process and to deal with the social stigma which may

be associated with being in therapy. Participants explored both providing information

directly to clients and educating the community. Community education was said to be

done both through current or former clients and through other means.

Psychoeducation was seen as one of the most, if not the most powerful tool to

engage clients in therapy. It is based on the perception that most Latino clients seen by

participants do not know what therapy is. And this lack of knowledge is seen as a source

of stigma. As one participant stated, "Latinos who may be less acculturated come in

with that sense of stigma or that sense of unfamiliarity with the therapeutic process."

It was reported that for clients to understand what therapy is, increases the

likelihood that they will remain attending it though it does not necessarily mean that

they share this with others. As one participant stated:

> Once they understand that therapy is not the kind of thing they had in their mind
> and they feared, it is easy for them to continue coming. But sharing with others
> that they are seeing me, that is different. And it can take much longer.

As reported by participants, from the very beginning of therapy they usually

share basic information with their clients:

> I go for the basics, you know, what is a doctor, what is a psychiatrist, what is a
> counselor, what is a social worker. I spend some time explaining to them what
> we do because most of the time they do not have a preference, they cannot
> know what they are doing here. So part of the process is kind of educational in
> nature to explain to them what they are supposed to be doing there.

The basic information about the meaning of therapy is sometimes provided even

before the first therapy session, during the intake phone call:

> Even before the first session, on the intake call, it has been very apparent at
> times when they have been recommended to call but do not know what to
> expect on the other line, and you can see them almost on the fence of making
> the phone call. And we reinforce their decision explaining at some point what
> they are calling about. This is important to underline during the intake call.

Touching on the issue of "being crazy" for coming to therapy was consistently

mentioned by participants as part of the basic information they provide to their clients.

All participants mentioned addressing this issue in one way or other. As one participant

summarized it, "It is very important to let them know that I do not work with crazy

people. And for the most part it seems to work."

For participants, the idea of "being crazy" shared by most of their clients comes

from the experiences those clients have had in the past. Since those experiences do not

reflect the entire reality of therapy, it is necessary to inform clients about it. As one

participant stated:

> I think that there is an educational piece that must be given. Most of our
> families have not been aware of it because of some particular experiences or
> maybe because in their countries of origin they only know about the extreme
> cases. You know when someone has been locked up or when some really bad
> stuff has happened so this idea that you can be healthy and be in treatment is
> really foreign language for them.

The meaning of confidentiality was also consistently mentioned as part of the

basic information provided by participants to their clients. Participants reported

presenting it linked to some aspects of the Latino culture:

> After that, we explain to them what confidentiality is and the difference with a
> barrio (neighborhood in Spanish) or the familia (family in Spanish) or friends in
> which everyone knows everyone else business. And if they are from a Roman
> Catholic background, I explain to them that confidentiality is almost like a
> confession. I explain to them what confidentiality means in working with a
> therapist.

The explanation about boundaries in therapy was seen as a significant piece

when providing therapy to Latinos. It was recognized by participants as an issue with

strong cultural implications:

Another thing that I found myself doing more with Latinos than with others is explaining about the boundaries present in therapeutic relationships. People do not understand it if they have not had a lot of experience with therapeutic relationships. They box it into a friendship which is the closest thing. I mean, here you are, pouring your heart out to somebody who is really nice and hopefully, gentle and considerate, and all these qualities, and so you automatically box the person into certain category which is familiar to you. And so I find myself explaining all the differences between a therapeutic relationship and a friendship, for example. And I do this as part of the therapeutic process because I worry that people might be offended or think I am better than them or whatever, which is certainly not the case at all. Because under other circumstances I would be glad to go to their fiesta (party in Spanish) and it is hard to refuse to socialize taking into account the cultural piece.

Participants reported positive outcomes for clients and the therapeutic process

as a result of explaining the boundaries issue:

My experience has been that explaining the relationship to a client is a relief because in their daily lives every relationship is so intrusive and so interconnected that to be in a relationship with some natural distance, caring at the same time, makes them find therapy more valuable as a resource.

The strong connection between physical health and mental health was reported

by participants as being used to educate clients about therapy:

A lot of people, when they experience physical symptoms, may think, "Well, I will go to see the doctor just for something physical." But they do not necessarily think of counseling as part of that. So, I try to make those connections for them so that they may say, "Oh, then there is a connection between what I am thinking and feeling, then maybe this (therapy) could be helpful" so that they might come back to see me. It is kind of an educational piece to decrease the stigma about mental health and all that. That is all part of the cultural part.

The use of a particular psycho-educational model of intervention was presented

by one participant:

What has always worked very well for me in working with Latinos whether it is in individual, couples or family therapy, is being mindful of a family-centered approach, an approach centered in psycho-education. My experience has been that when you explain to Julian about the context, that you are not crazy but let's talk a little bit about families and how each family member affects other family members and since you and your wife have very different backgrounds, clearly it is affecting how you parent your two children. So that even though she wants you to come in order to address these issues, it does not make you internally crazy, but it means that you may need some help in working out your differences—the different values, expectations about family, family roles—and from where those differences are coming. And sometimes it is very helpful to have someone else to discuss those things in a safe place. And it has been, in my personal experience, really effective for working with Latinos.

Participants highlighted the importance of individuals who have experienced therapy as ambassadors to educate others in the community and eliminate the social stigma around it: "The best promoters of a different perception of mental health and breaking this social stigma attached to therapy are the same clients. They are the best outreach for your program."

In terms of educational campaigns targeting the Latino community at a broader level, and in order to educate Latinos regarding mental health-related issues and dealing with the stigma associated with therapy, participants recognized the importance of such efforts but did not see them happening as much as they wish:

I think we are all new to this at a broad level. It has only been recently that you see television commercials talking about depression and how it affects the men in the family. Some people who have seen this campaign have ongoing depression. They are showing these people in the kitchen who cannot function with their daughters and the man who cannot talk to his wife. And, you know, this is for pharmaceutical purposes, to sell antidepressants, but there are some agencies very involved with the whole community, with wellness initiatives that seek to educate the community, the broad community with the focus on Latinos

and African Americans about mental health issues and depression. And this is a good beginning, but it should be part of a larger campaign and a larger community outreach. I think it would be nice to see some of that shaped, personalized or individualized to the Latino community in a way that Latinos can identify with it, that they can understand it. But I don't think we are doing anything like this. In my experience we do not have any kind of real specific community outreach to say [that] this is what therapy looks like and it is okay to go to therapy and here is why this is so beneficial. That very intentional strategy to get rid of that social stigma, I do not think anyone is doing that.

Participants provided some specific examples and agreed that establishing alliances with churches is one of the best ways to educate the Latino community at large in mental health-related issues and dealing with the stigma associated with therapy. This conclusion was based on the sense of religiosity common among Latinos and the cultural notion that private issues cannot be discussed out of the family or the church. As one participant stated:

I think the assumption here is that Latinos, as a large and diverse group, continue to maintain a strong sense of religiosity. If this is true and if we have said that social stigma about therapy comes from the idea that airing dirty laundry cannot happen out of the family or the church, then these institutions carry a lot of weight, a lot of influence when we talk about reducing the social stigma. It would be crucial to get collaboration with churches in order to help promote the message that counseling with educated, secular professionals is okay. That it is not a betrayal to your church or to your family to be discussing personal issues with those professionals.

The node **"clinician role boundaries"** refers to how the expectations about the clinician's role in therapy and the way the clinician responds to them may impact the engagement process and the issue of stigma.

The potential conflict between clients' expectations and clinicians' role was summarized by a participant:

> It has been my experience that the stigma comes with the concept and the implications for them regarding what they believe. What they expect from therapy sometimes interferes with what I as a therapist want to provide to them. The issue of "giving advice" was presented by participants as a common

expectation among Latino clients in therapy. The conflict it presents for clinicians was discussed. As one participant stated:

> I have found clients saying "Digame que hacer" ("tell me what to do" in Spanish). And as much as you try to throw them back, a lot of research has been done in terms of showing that if you do not do that, they walk away feeling like "Well, I am paying them to give me advice. They do not want to tell me what to do, so they are incompetent." So, there is so much need for psychoeducation, to explain to them, "Yes, I am the expert but I am not going to be here to tell you what to do." And this can be a very frustrating dance. Furthermore,
> I just talk to her as "Okay, you are not here because I am going to tell you, you are crazy or something like that. The thing is that you have something you cannot see and maybe I can help you to see."

Another participant provided an explanation about the "giving advice" issue:

> I want to say I guess that goes with a cultural Latino value about education in the sense of trusting professionals.   Like you tell me what to do kind of thing and I will follow the teacher, the doctor, the priest. There is a cultural value that tells us that we follow the leader. I think that is where it comes from.

The use by Latino clients of the title "doctor" to refer to their clinicians who are not actual doctors and the cultural significance of it were also discussed. As one participant stated:

> I am called doctor all the time. At the beginning I used to say, "No, I am not a doctor." But I get tired of saying that. I still do it the first time, but if they continue calling me that, I just let it be. It is like "Well, I am not a doctor but if

you want to continue calling me that, it is okay." Because it is about the distance between you and a regular person, between an everyday person and the doctor over there, it is a position of authority.

A possible connection between the use of the word "doctor" in reference to

clinicians and stigma was presented by some participants. As one of them stated:

> I think this is related to the idea that it is okay to see a medical doctor for as many times as you want and this is not an issue. So, when I saw some of my clients probably they did not tell anyone that they were seeing me. But probably they said, "I went to the doctor" and that was okay.

A great deal of discussion happened among participants in regards to self-

disclosure about some aspects of the clinician personal life as a necessary element in

engaging Latino clients in therapy and eventually helping to deal with social stigma. As

one participant stated:

> Another thing I think is interesting when engaging with Latino families, something different than when working with other cultures, in my experience, is that Latino clients want to know where I am from, they want to know what generation I am, and this is an interesting aspect of self-disclosure because I share. I think that whether clients stick or not in therapy has much to do with finding some common ground with the clinician. The want to know if I eat tamales (a kind of typical food); they want to know more about me before engaging further. And I feel that if I do not share—I mean certainly what is appropriate—I would lose them, I would be cutting the relationship off. And so, I share. I share where my parents are from, that I was born here--those kinds of things. And I think that addresses stigma. You know, how much are you like me, how different are you from me, how are you going to help me and my family? And I think that a lot of that "dance" happens at the beginning of therapy.

Another aspect of self-disclosure which was discussed by participants referred to

the tension between maintaining strict boundaries and disclosing the fact that the

clinician is or has been in therapy.

For some participants, this kind of self-disclosure helps to de-stigmatize therapy:

> I use that (saying that he has been in therapy) as a way of normalizing and as a way of de-stigmatizing. Coming from a man saying "Well, I have gone to therapy and it is something I have engaged in." I think it takes the edge off of it.

For others, it is important to be cautious about the timing for that kind of self-

disclosure taking into account the negative effects it may have on the client:

> What I have found about my clients is that they need to experience you as somebody who is put together at least for the first couple of sessions. Sharing that you are in therapy may raise some anxiety in them. Like, "Oh, so you are crazy too."

Overall, participants agreed that the important point with self-disclosure is

finding if and when it might be beneficial for the client. As one participant stated:

> I think the underlying point with disclosure is to be aware that we go to counseling with our own personal heritage, culture, family beliefs, and it is important to disclose when it is appropriate and beneficial for the client, so we need to always assess about it at any point in treatment before disclosing.

With no exception, participants saw the need to be more flexible in their

boundaries with Latino clients taking into account that for clients asking personal

questions is a culturally appropriate way to connect and if clinicians do not respond it

can in fact harm the therapeutic relationship. As one participant stated:

> I think that those questions are usually just pleasantries or little chit chatting. Not answering them, staying completely behind a wall I think can sometimes contribute to the client feeling crazy because they might ask a question that culturally is just a way to connect and I have had the experience, if I do not answer, I have felt the client—you see the reaction going on in their heads that they say, "Maybe this is not a safe place."

Another situation related to flexible boundaries discussed by participants

referred to involving others in order to have access to the client. As in the example

given by one participant:

> One of my supervisors had a case where the grandmother, a first-generation
> Mexican, was the owner of the house, and the real force in that house. And the
> entire family—five children and their parents—lived in the same house. The
> mother of one of the families, who lived in the basement, had postpartum
> depression and the matriarch would not allow her to have services. The mother
> was visibly depressed. So we had to work with the matriarch because without
> her approval nobody could do anything in that complex.

Physical contact as part of the culture and its implications for therapy were

discussed. The discussion focused on the way in which clinicians observe the cultural

norms and incorporate them as part of the clinical boundaries. As one participant

stated:

> That has two sides to it. I agree with what you are saying (that it is necessary to
> be extremely careful with physical touch), but on the other hand in the Latino
> culture, it is so normal to give a hug when you greet somebody or when you say
> good-bye. It becomes almost a natural thing. So one has to be careful not to go
> to the other extreme where it feels like a rejection. I always think about the
> client, how he or she presents the petition, the kind of petition it may be; but if
> they reach out and want to give me a hug good-bye, it is fine. I think it is going
> along with the culture.

Participants expressed the need to play multiple roles with their Latino clients.

Participants saw their playing all those roles as part of therapy and fundamental in the

engagement process. One participant provided a rich example of this:

> I am thinking about the role we play with Latino families when we engage with
> them. Depending where they are in the acculturation, in the family chaos, in
> their own kind of narrative of their immigration story, at times I feel more like a

role model, or a mentor rather than just a therapist because I am somebody who has grown up here and is educated and has a job. And maybe that is something that the family has not experienced. I remember I had this Colombian family, they were here on political asylum and the 11 years old boy who was the identified client had several physical problems and was being treated at (name of the hospital). And a lot of the sessions with them were regarding how to really navigate this world. Like this is a stop sign, or you cannot park in the yellow because you will get towed. There was a lot of showing her how to use the bus so that the mom could get the child to the doctor's appointment. And so that, you know, is that therapy? Absolutely--like absolutely that was therapy for this family. I think that we just play these different roles with Latino families that are so valuable. You know, when I think about all those relationships and how people use us, I think that is so much more than therapy, per se.

The node **"groups"** is related to different aspects of the use of group therapy—understood in a broad sense which may include not only therapeutic but also psycho-educational and support groups—as a privileged way to engage Latino clients in therapy and to deal with the stigma which may be associated with it.

Participants consistently reported group therapy as being a particularly effective clinical intervention with Latinos:

> What I was about to say is that that is a whole other study in the future, because just anecdotally, right now anecdotally you have three, four, five people in this room who have experienced the effectiveness of group process as a clinical intervention with Latinos.

Social stigma was mentioned by participants as a barrier for people, especially men, to join groups:

> It is particularly relevant for men, for Latino men, to join the group. They are very resistant to come but once they are there, I think they are able to engage. But it is getting them there the difficult part because of their feeling that they may be crazy or that they are going to be stigmatized."

Participants discussed what makes the group experience unique and how it helps

to deal with the stigma associated with being in therapy:

> You are normalizing the fact that it is okay to talk about this, that she is seated across the room and she has experienced some severe depression that she has thought about suicide which is the most taboo conversation. For example, in my groups that is the most taboo thing to say in the real world—that you would consider suicide—especially when you are coming in with that very strong sense of religiosity or spirituality. Many of them are predominantly Catholic and so to be able to say that in a safe place is so powerful. It is so impactful and you can only maybe get that in a group. You can see the same woman in individual therapy for one year or two and maybe she will never feel comfortable to say it because of the cultural norms and values that come with saying something like that especially when you have children that you may be leaving behind. But in a group process Latino women and men tend to really disclose—it is so powerful. I do really think is the most powerful intervention that I have encountered with Latinos.

Providing information about the group process was consistently mentioned by

participants as a strategy to deal with the social stigma associated with attending group

therapy:

> At the beginning we do a lot of psycho-education around this process. And that this process is okay. We address early on those feelings of the stigma that you do not discuss private issues with others outside of your family or outside of the church.

Furthermore, many participants see the process of educating clients about the

meaning of therapy as happening better and faster in groups than in individual therapy:

"When you are providing psychoeducation individually it is a long, arduous process; you

can go on and on. But in a group, it is so accelerated because you are normalizing every

single experience*."*

According to participants, high-retention is a specific outcome of group therapy.

It results from the sense of connection clients experience in groups:

My experience is in the group work that I do which is 100% with Latino women and men. We have some group participants who have been coming to this group I think maybe up to seven or eight years. It is an open-ended group and as a facilitator I see that they have addressed their presenting issue, but they themselves will report that they feel a sense of connectedness and that this is a place where they can continue to come and express and share other life issues.

The importance of groups for Latino men was highlighted by participants:

I think something to be explored is if group work really should be the premier technique or model to use with Latino men. And I think this is the case, even when working with abusers. Working with abusers the group process seems to be the most powerful tool that we can use.

Ways in which men can be engaged in groups were discussed:

For the first maybe five or six years our group consisted of all women. And then, for the last two years a young couple came in, younger, highly acculturated; so there were generational and acculturation issues. It was a Puerto Rican couple and shortly after a younger Mexican-American couple came in. The husband preferred to speak in Spanish so the wife was willing to come to the Spanish group. Once these two men were incorporated or injected into the process, within months the veteran women who had been coming to the group for years started putting high pressure, what we would call high pressure on their husbands who had refused to come to the group for years. And recently, this group turned into like 16-20 people and this is because they are all couples now. And these older, very traditional Mexican gentlemen were seated there listening to the two younger guys and all of a sudden they were also talking. The attendance has just sky-rocketed. They are around other men, they are hearing other men across the circle saying things that they are thinking and they are [being] given permission to start to engage.

For participants, groups in which men interact with other men help to deal with

the shame they sometimes associate with being in therapy: "Suddenly, they do not have

to be ashamed because there are other guys there. It speaks of the power of the group

process for Latino men."

The eventual co-responsibility of clinicians in perpetuating the stigma associated

with men participating in groups was presented and explored by participants:

> We have talked a lot about group work with men in the context of men, in the
> context of mandated interventions. The groups we are familiar with in terms of
> Latino men are either for DUI's, or perpetrators, deviance issues, sexual abuse
> issues. So, I think, are there groups that we have intentionally formed at a
> community based agency? Is one of us saying we are going to do a group for
> men who may be depressed, or for men who may be having relational issues, or
> who may be having transitional life issues? We do not think that way because
> we may be buying into the same stigma, the same social stigma issues leading to
> say, "Well, they are not going come. They will not come." So why do we do this?
> We are products of the culture. In many ways we have to look at how much we
> are perpetuating the social stigma in that we do not offer these safe non-
> mandated interventions that might help reduce the social stigma, at least in the
> context of the male.

Dropout Factors

Two nodes were organized under this tree which refers to the factors clinician

participants perceive as determinant for clients' dropout: general dropout factors

(GenDropoFact) and stigma dropout factor (StigDropoFact). The node **"general dropout**

factors" refers to what participant clinicians understand as dropping out of therapy and

those factors, other than stigma, which can be associated with abruptly leaving therapy.

It was discussed by participants how sometimes Latino clients may abruptly

leave therapy but because they established a relationship with the clinician and

experienced the benefits of therapy they come back later on, at some time in their lives,

even many more times. As a result, it is not clear if those situations constitute or not

"dropouts." As one participant stated:

> It is hard to define "dropping-offs" and "dropping-outs." What I see with Latinos
> is that they come for the sessions they may think they need and that is it, but
> they really connect with you and then they continue coming all their lives on and
> off. And it seems to be unique or not unique but particular to Latinos.

Participant clinicians consistently reported not having a significant number of

clients who abruptly stop coming to therapy after they have attended their first session.

As one participant said, "What I noticed is that when you said that Latinos have a

dropout rate four times higher than Caucasians I thought, 'Well, I do not see that.' A

small percentage, yes, but it is because they move around so much."

Nevertheless, several factors other than stigma were understood and mentioned

by participants as causing Latinos to sometimes abruptly stop attending therapy:

financial factors, geographic mobility, issues related to lack of documents, the need or

desire for ventilation but not for treatment, not being ready for dealing with some

issues which become or may become the focus of therapy.

These are a few quotes related to the formerly-mentioned dropout therapy

factors. One said:

> Especially with Latino clients they face some other factors that you need to
> consider. The biggest struggle for them is the economy, and we have seen a lot
> of this lately. It is because they have a crisis, or a basic need that needs to be
> attended first.

Another said:

What many clients do is to treat therapy as a one-time consultation—I come, I get it out of my system, but I do not want to be in treatment like a crazy person. Let me see how it goes for the next few weeks and if I am still having trouble, I will call you back.

Another stated:

I think when people see something they do not want to see or they are not ready that is when they do not come back. They realize like "Oh, she is going to ask me about that and I do not really want to talk about it. I had not thought about it in ten years and now it is coming up, why?"

Another observation made was that "they cut short (therapy) for different reasons, for moving especially, or some of them because they did not have documents and were deported."

The node **"stigma dropout factor"** refers to the role social stigma may or may not play as a factor for Latino clients to drop out of therapy from the perspective of participants. Most of the participant clinicians explicitly indicated that they do not think of social stigma as a factor for Latinos to drop out of therapy though it can be a factor preventing them to start therapy. As one of them stated:

I never think that (dropping-out) it is because stigma, to be perfectly honest. I do not think that it has ever crossed my mind that I thought "Oh, it was stigma that is why they did not come back." Now, that they did not show up the first time because of that, possibly. But when they do not show up for the second appointment, then, I do not think they are not coming because it is stigmatizing them.

Some participants referred to cases in which some of their clients stopped attending therapy for the stigma associated with it, but were able to overcome it and returned. As one of them stated:

> When my clients are coming and they are making it happen for a few weeks and they stop coming, it sounds like they are trying to decide which pain to endure better: is it the pain that they are going to feel during the therapeutic process or the pain of dealing with the stigma outside of my office? And you know, they come back and say "I feel safer here and I am back to continue with the course of my therapy."

Nevertheless, participants recognized that there are times when they do not really know why their clients stop coming to therapy. They mentioned that possibly they miss the opportunity to know if it is because of the stigma because they do not even think about it. As one participant stated:

> What I am thinking now about my clients that did not return or did not keep their follow-ups as recommended is that stigma could have been there and I just did not know. So it (social stigma) probably plays a lot and I assume it is not there but I do not specifically assess for that and then I do not really know because they never come back.

Summary

Three focus groups were used to gather data from fourteen bilingual Latino therapists (social workers, psychologists, and counselors), who practice in the Chicago metropolitan area, and have at least five years of experience providing services to Latino clients in order to address the research questions related to the impact of social stigma on the therapeutic relationship and the way in which clinicians address it. The data was organized in three trees and seventeen nodes using the computer software program NVivo. The importance of engaging clients in the therapeutic process with extreme cultural sensitivity, and through it, addressing the social stigma that those clients may

be experiencing, was a prevalent theme identify by study participants throughout all

three focus groups.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS, AND IMPLICATIONS

The intent of this qualitative study was to explore in depth the influence of social stigma in psychotherapy with Latino clients; and the ways in which Latino mental health clinicians address this issue in their practice. Furthermore, this study intended to consider the role of clinicians in addressing social stigma in psychotherapy and identifying strategies for dealing with this issue. The ultimate aim of this research was to improve mental health service delivery to the Latino population. The specific research questions were formulated as follows: (1) What is the impact of social stigma on the therapeutic relationship? (2) How do clinicians address social stigma in psychotherapy? This chapter presents the ways in which the study results, based on the literature review, answers the research questions and supports the assumptions of the study. This chapter also highlights the conclusions of the study and points out, based on the study results, some of the implications of the study particularly in regards to areas for further research.

Social Stigma Definition

This study provided a tentative definition of stigma as the internalized fear of severe social disapproval by behaving against acceptable cultural meaning systems,

norms about mental health issues and treatment. After analyzing the data results, the

tentative definition remains unchangeable though its meaning has expanded.

Participants mentioned three main cultural meanings assigned to being in therapy and

associated with social stigma among their clients: being crazy, sick and weak.

Additionally, they mentioned shame for needing help and guilt for sharing too much

about personal issues. In this study, participants confirm the literature findings in

regards to all these issues as being commonly associated with the social stigma for

attending therapy not only among Latinos but among other cultures as well. They also

explicitly confirm the literature findings in regards to the cultural values of *dignity,*

respect, familialismo (being family-oriented) and *aguante* (the ability to withstand

stressful situations during difficult times) as being the roots for all the mentioned

cultural meanings attached to therapy stigma among Latinos. Especially, the popular

saying in Spanish, "la ropa sucia se lava en casa" (dirty laundry is to be washed at home)

was repeatedly mentioned by participants as a reflection of the tendency of their clients

to behave and conform to acceptable social norms, avoiding discussing personal issues

outside their family, doctors and priests/pastors because doing it may be embarrassing.

Therefore, the study confirms cultural barrier theory as an explanation for underuse of

mental health services.

    Participants presented, however, two unexpected additional cultural meanings

associated with therapy stigma among some of their clients: (1) one form of stigma

originated within the family coming from the fear that when a person gets involved with

someone of the other gender in an intimate relationship like the therapeutic

relationship, it may lead to cheating on the spouse who is not attending therapy and (2)

a more complex form of stigma consisting of the expectation that clinicians provide

advice and if they do not do that, they are seen as incompetent, and therapy is

perceived as a waste of time and money. The first of these two forms of stigma seems

to be rooted in the values of respect and familialismo which involve maintaining strict

boundaries among married individuals with members of the opposite sex. The second

one seems to be based on the hierarchical social structure of the Latino culture within

which each individual based on his/her position in it has specific roles to fulfill.

Population

Though some participants reported having Latino clients coming from diverse

backgrounds and socio-economic status, all of them reported having clinical experience

and a caseload formed almost exclusively by Latinos who are immigrants coming from

rural areas, many of them undocumented, with low-income, low-education level, low

levels of acculturation and a significant lack of knowledge and/or understanding about

the therapeutic process. When engaged in the focus group discussions, it was clear that

participants, except when otherwise mentioned, were talking about that specific group

of clients. Therefore, the conclusions of this study, even though not designed to be

generalized because of its nature, refer to that particular group of Latinos who

constitute the vast majority of participants' clients.

Social Stigma Impact

The question about the impact of social stigma on therapy with Latinos from the

perspective of the population served was only partially answered by the study.

One of the beliefs used to support making the focus of this study the Latino

population in general rather than a specific group of Latinos was challenged by the study

results. As a matter of fact, participants recognized social stigma as a reality negatively

impacting some but not all of their Latino clients to remain in therapy. It was believed

at the beginning of this study that stigma is expressed and impacts in similar ways all

different categories of Latinos despite their national origin, race, financial situation, and

educational and acculturation levels. It was presented as a possibility and recognized

now, however, that there may be differences in both the quantity and the quality of the

impact of social stigma upon different sub-groups of Latinos. It is also recognized that

those differences may be reflected in the therapeutic relationships established between

individuals belonging to those different sub-groups and their clinicians.

Latino immigrants coming from rural areas, particularly those undocumented,

with low-income, low-education level, low levels of acculturation and a significant lack

of knowledge or understanding about the therapeutic process are perceived by

participants as being more prone to the negative impact of social stigma and are at

higher risk for not being engaged in the therapeutic process. In spite of it, participants

describe many of those clients as coming to therapy ready to be engaged and to remain

in therapy, not showing any negative effects of social stigma: "I would say that a large

group of people come in knowing what they want and feeling comfortable with it."

This is a major, unexpected finding of the study. The surprise of this finding

comes from the difference found when comparing it with the perception of some

authors like Shattell and others (2008)—and also shared by the researcher—that even

for those Latinos who have sought out and have begun receiving mental health care,

social stigma still poses a significant barrier to remain in care. The factors allowing

those Latino clients to be ready for and to remain in therapy merit further research.

Latinos on the other side of the spectrum, with the opposite characteristics,

seem to be assumed as sharing some of the characteristics of individuals from the

dominant culture, among them being less affected by social stigma. As a result, as one

participant stated it, Latinos who are more acculturated are treated differently in

therapy, like mainstream Anglo individuals. It poses a question which could be a matter

of further exploration, related to an extent, to the way in which those more

acculturated Latinos behave is or not independent from the way in which they are

treated by their clinicians.

The impact of social stigma on Latinos with different combinations of

characteristics such as those new immigrants highly-educated but low-acculturated

remains unanswered. Therefore, further research on the impact of social stigma on

stratified segments of Latinos attending therapy is necessary.

The circumstance in which Latinos are sometimes referred to psychotherapy by

their medical doctors, spiritual counselors, or other authority figures was initially linked

to their attending perhaps one session but thereafter missing appointments, being

unwilling to contribute to the therapeutic process, and even dropping out of therapy.

This assumption was based on the belief that even though Latino clients may feel the

obligation to attend psychotherapy to satisfy whoever referred them, it increases the

negative impact of social stigma because they perceive their problems as being more

serious and therefore, more private. This assumption was not confirmed by the study.

Rather, it was perceived by participants that clients referred by a trusted source not

only increased the likelihood of attending a first session but also of remaining in

therapy. However, it is not clear if when this happens, that this is the result of the

referral itself or the successful engaging strategies used by clinicians.

The question about the eventual negative impact of social stigma on therapy

continuity also remains unanswered in regards to clinicians with characteristics other

than those of the sample, specifically, on therapy provided by non-Latino and/or less

experienced clinicians.

It was stated by some participants that the high drop-out rate of Latinos from

therapy probably happens more frequently among those receiving therapy from non-

Latino clinicians: "The truth is that the drop-out/drop-off rate seems to be higher when you do not come from the culture."

This explanation seems initially appealing, but at the end, its implications are at least incomplete since they do not take into account the clinician's experience regardless of her/his ethnicity. Since participants were all Latino individuals with at least five years of experience providing services to Latino clients, their experience is a factor to consider when comparing their success in engaging clients and dealing with social stigma with the outcomes of non-Latino clinicians and other less experienced Latino clinicians. This is an important topic for further research.

Even when present, clinician participants do not perceive social stigma as an insurmountable barrier permanently impacting their clients. On the contrary, participants have experienced that social stigma negative impact, once clients are engaged, disappears rather quickly and their Latino clients tend to remain connected with them by staying in therapy, coming back to therapy, or in some other ways:

> I had somebody that I saw many years ago who moved to Mexico and she still writes to me by e-mail. I really do not know how she got my e-mail but she writes saying, "Well you know, that happened and this happened." And she was one of the most resistant to therapy.
>
> Furthermore, it is very hard to disconnect from them because you see that they do not need the service anymore, but they still want to come. So the work is to disconnect.

Clients who have experienced an engaging therapeutic relationship are perceived by participants as assets to combat the negative impact of the social stigma

related to therapy in the Latino community: "When clients do develop that relationship

and that rapport and they start seeing the value of therapy, my experience has been

that they become the best advocates for others about what therapy is about."

This perception is particularly relevant for the study confirming findings in

regards to social stigma as a major barrier for Latinos to access mental health services

and therefore in need of being addressed.

Addressing Social Stigma

The question about how participant clinicians address social stigma in their

practice with Latino clients was answered in rich and sometimes, surprising ways.

Social stigma is not seen by participants as an independent entity but as one more

element to be addressed as part of the overall task of engaging clients in therapy:

> I did not see it necessarily in my mind as assessing for social stigma. The way in
> which I kind of framed it in my head was that I was helping clients to socialize
> into the counseling situation. So in my mind what I was doing was preparing
> them to get their expectations, but also to kind of get a sense of what this is
> going to be like. What are the kinds of things we can do and what are the things
> that we cannot do. Let's see if there is a match, you know, working very
> arduously to find a match so that they would, you know…but kind of addressing
> their unrealistic expectations because they also come with unrealistic
> expectations of counseling. And that is how I address social stigma. Now that I
> think about it, I had never really thought about it that way, but that I was
> socializing them into the counseling situation or relationship.

This perception of social stigma as a "no-big-deal," independent issue to be

addressed by the clinicians is a major unexpected finding of the study. The surprise

about this finding comes from the researcher's expectation that clinicians, when

reflecting upon social stigma, would see it as a main, independent issue playing

negatively in the therapeutic encounter.

Participants do not seem to be intentional about addressing social stigma when

they engage their clients in the therapeutic process. Rather, they report a conscious

effort to consistently, methodically and eventually successfully engage their clients in

therapy: "After working with this population, you know, working hard, I have not had a

client who did not come back a second time or a third time."

And a more intuitive process in which they intervene to deal with the social

stigma associated with being in therapy is:

> I do not think about stigma and things like that. I think it is just an awareness for
> me as a therapist while I provide treatment to Latino families, while I engage
> them being empathic and sensitive. Kind of keep that in mind and not to
> minimize it; but just an awareness.

This finding confirms one underlying assumption of this study, that clinicians

seldom purposefully address the issue of social stigma once the therapeutic encounter

has begun, though they sometimes unconsciously may intervene to overcome it. Some

participants, as a result of their participation in the focus groups raised their awareness

to these unconscious interventions and expressed their intention to continue using

them in the therapeutic encounter in a more intentional and even efficient way. This

was precisely one of the goals of this study: to draw clinicians' attention to their role in

dealing with social stigma in psychotherapy.

It is broadly recognized in the literature that the engagement process of ethnic minorities—and Latinos, in particular—requires the provision of culturally-sensitive services by culturally-responsive providers (McKay et al., 1998; Grote et al., 2007). The ability to effectively address the barriers brought to treatment by clients is one of the characteristics of culturally-responsive providers consistently mentioned by the literature (Lopez et al., 2008; Cabassa, et al., 2007; Ojeda & McGuire, 2006; Grote et al., 2007; Shattell et al., 2008; Añez et al., 2008).

In this particular study, taking into account the fact that all participants were Latinos, the intuitive manner of addressing social stigma seems to be linked to the world view of those clinicians. The world view of these clinicians is permeated by similar socially-constructed beliefs and narratives as those of their clients. Therefore, issues such as stigma are well-known and probably have been experienced by the clinicians and/or those in their immediate environment, making it natural for those clinicians to address them:

> I think that definitely being Latino makes you able to engage them in a culturally confident manner because there are many things we do not have to learn because we might already know and understand.

This conclusion seems to be confirmed by the fact that the clinicians' culture was mentioned by participants as the main facilitating factor to deal with the social stigma associated with being in therapy and to engage clients.

Participants see the clinician as the one directly responsible for engaging clients in therapy and addressing those risk factors, among them social stigma, which may prevent the engagement to happen. This finding confirms an underlying assumption of this study—based on Intersubjectivity theory, which constitutes this study's theoretical framework—according to which addressing social stigma in psychotherapy is a clinician's role which has a direct impact on the therapeutic relationship.

However, a complementary assumption of the study was not confirmed by the study findings: that the clinician's failure to address social stigma may prevent the therapeutic process from moving forward successfully and eventually lead to therapy impasses, attrition, and early, abrupt terminations by clients. This assumption was based on the literature which associates social stigma with attrition and abrupt termination of psychotherapy (U.S. Department of Health and Human Services [USDHHS}, 2001; Vega et.al., 1999; Añez et. al., 2008).

This assumption could not be confirmed because participants strongly believe that they deal successfully with any risk factor, including social stigma, which may prevent them from engaging their clients in therapy and because in the case of those clients who drop out of therapy, participants believe clients do not leave unexpectedly because of the social stigma, but because some other factors independent of it such as cost, geographic mobility, documentation issues, need or desire for ventilation but not for treatment, lack of readiness for addressing unsolved issues in therapy. The factors

mentioned by participants as barriers for Latinos to remain in therapy coincide with

some of the most commonly-mentioned in the literature (Añez et al., 2008; Shattell,

Hamilton, Starr, Jenkins, & Hinderliter, 2008; Van Hook, M., 1999; Grote et al., 2007;

Ojeda & McGuire, 2006; McKay et al., 1998; Choi & Gonzalez, 2005; Cabassa, Lester, &

Zayas, 2007). Nevertheless, more research is clearly needed as to whether different

types of barriers serve significantly to remain in psychotherapy.

Participants are confident that no matter how it presents, social stigma can be

overcome with the use of adequate interventions by the clinician as part of the

engagement process:

> I feel that if they (clients) come through that door, the chances of them coming
> back are really high. If they never make it to my door then it is a little bit harder.
> Like if someone schedules an appointment and then does not come, misses it
> and you try calling them again—ehh, then you have a 50-50 chance. But after
> they have made it through the door, the issue of stigma is done for me; that has
> been my experience. Maybe they will not tell people that they are coming, but it
> depends on the situation. But what I find is that after that piece they sort of like:
> Oh, okay, this is all what it is. Nothing is going to happen to me. You know, I am
> not going to be treated in a certain way; I am not crazy.

This finding brings renewed hope in that clinicians' adequate interventions may

be replicated and eventually lead to a more successful engagement of clients

diminishing and hopefully neutralizing the possible effects of social stigma on attrition

and abrupt termination of therapy. This finding is also particularly relevant taking into

account the consistent findings reported by the literature in regards to a successful

engagement as being the best predictor of positive therapy outcomes (Krause & Lutz,

2009; Clement, 2008). This is also consistent with the notion of *surrender* coined by Jessica Benjamin (2004)—an Intersubjectivity theoretician—according to which the efforts of clinicians to take in their clients' points of view or realities leads to the experience of a profound connection between clients and clinicians.

The social stigma associated with taking psychiatric medication is perceived of as stronger and more difficult and participants find more difficult to deal with it in comparison to other forms of social stigma. Individuals with a psychiatric diagnosis which requires medication are seen as *"damaged people. And if you have a disability, you are on the fringes of society and it is difficult to tell them, to educate them in that the person is not damaged, that you can be proud of the person because there are X, Y and Z things that they can do. And to change this takes a long time. I think this is the major stigma I have been working with."* This seems to confirm the findings in some studies (Van Hook, 1999; Cabassa, et. al., 2007) according to which taking medication implies a severe illness and a weakness or failure to cope with problems. However, it could also be in conflict with another finding of this study according to which being diagnosed with a mental illness or disorder can be positive rather than negative for some clients based on the non-dualistic approach Latinos uphold in regards to the body-mind connection.

Participant clinicians use a variety of strategies they have found in their experience to be successful engaging their clients and addressing social stigma. The two

more commonly mentioned were the willingness and ability to use more flexible

boundaries with their clients:

> When I compare how I work with Latinos and other groups like African-American[s] and Caucasian[s] or other groups, what has become very clear to me is that I behave differently with each one. And that is what brought to my attention and made me notice more the cultural aspect of each group. Latinos need the boundaries to work with them, [to be] more flexible. With other client groups they do not need that at all. In fact, they do not want it at all. And with variations, of course, because you cannot generalize, but in general, definitely Latinos need a little more flexibility of boundaries.

And they need psychoeducation, broadly understood as the provision of information to the clients in regards to the therapeutic process. The strategy of psychoeducation is based on the fact that for most of the participant clients' the social stigma associated with being in therapy comes from their lack of experience with and knowledge about the therapeutic process:

> For some of us that are born here, that are acculturated, those that are Anglo, we see this on TV, we know what therapy is, we have understood and embraced the term growing up. We may know people who are in some kind of therapy or group work, but Latinos coming in who have migrated, who are immigrants; they do not know what therapy is. Not really, they do not have a sense of what that is. And so much of this is psychoeducation.

The use of both strategies by participants, flexible boundaries and

psychoeducation, is recognized as being directly related to some Latino cultural values

such as *personalismo*.

Some other strategies mentioned by participants to engage their clients and

address social stigma were: the provision of a safe environment in which client and

clinician can work together, normalizing the therapeutic process, being empathic, and

both exploring and emphasizing clients' strengths.

Even though it is clear that this is not a linear process, the engagement of clients

as described by participants could be hypothetically summarized as follows: From the

very beginning clinicians start providing information about the purpose and meaning of

therapy with statements such as "this is not for crazy people," "I'm not here to tell what

to do or what not to do but to help you to become aware or discover your own

answers," "we are here to work together," and the importance and meaning of

confidentiality using culturally sound comparisons such as living in a *barrio*

(neighborhood) and confession with a priest, which makes it easier for clients to

understand. Clinicians ask about and listen to the stories of their clients, especially

regarding their immigration journey and their lives before migrating. They ask, "Can you

tell me how you came here and tell me a little bit about your journey here?" And that

communicates a sense that I am interested in you as a person and not just as a patient.

And that generally helps people feel like, "Oh, okay, he is talking to me just like we are

two people here and he sees me more than just a problem," that he is intrigued. And

this is one of the ways in which I do things differently in the first session. Clinicians

acknowledge the stories, normalize without minimizing what clients describe as

problematic in those stories, and pay particular attention to the presence of culturally

sensitive issues in those stories. One said:

> It really becomes essential for the clinician to engage and become sensitive to
> some of these sensitive areas such as abortion, culturally significant topics that
> tend to be very difficult for people to address. It is something a clinician needs

to be very sensitive of and very aware of especially within the first session. And I think that retention is very related to that.

Clinicians praise clients for making the effort to attend therapy which is explicitly recognized as challenging. One commented that:

> She came alone and I would reinforce her being able to do things on her own, particularly as a woman where she does not seem to be attached to following someone. And I would explore if coming to therapy is like other struggles she has faced to become a strong, independent woman.

Clinicians mirror and further explore the strengths of clients who are perceived as survivors. One participant stated that:

> I would explore how she has coped the last year and a half, exploring how she has been able to function given all the challenges, trying to identify how she has managed her life this year and a half and build off of that.

When clients have been referred, clinicians start exploring the reason for the referral, particularly health and spiritual issues. In order to provide a holding environment, clinicians self-disclose and engage in physical contact with their clients within the cultural norms and always following the ethical principles of their profession and considering the well-being of their clients, clinicians are all the time "very mindful of the culture and how significant others of a client will see us." They see this as unique when working with Latinos. Another comment was:

> Although I know among the Anglo therapists they do not understand why I am so deferential to the husband, I have to because I do not want to create more problems to my clients when they go home. Many times, I am not encouraged, but it is okay for me to allow the spouse or the significant other of a client to come and check me out. They need to know who I am and what I am doing.

Clinicians sometimes protect their clients from the possible negative impact of social stigma not only allowing, but even suggesting to their clients not to disclose their being in therapy. Another one said:

> When they are leaving my office, the thing is not if they are coming back to see me, it is how they are going to be handling the situation outside, you know, by saying or not saying. I think they need to feel that they are secure and "just because you are coming here you do not need to tell anybody that you are coming to see me, okay?" And they agree with that. They need to listen to that because they get criticized a lot by their families, their friends, you know, people around them and they start questioning about the reasons for which they are coming to see me. And it is very hard for them to bring those issues outside of the office. And so, I really personally address the issue directly.

Clinicians do not pathologize their clients and when the need to diagnose appears, they try to use friendly diagnosis; no participant mentioned going through a "check list" in order to assess their clients.

The use of the described strategies to address social stigma and engage their clients in therapy by participants occurs with particular intensity in the first and sometimes second session. Clinicians perceive those strategies to be so successful that as a result, after the first or second therapy sessions, clients are engaged and social stigma is not an issue anymore. Though, one participant mentioned stigma as an ongoing issue which could surface or reappeared in the course of therapy making necessary for clinicians to be constantly attentive to it. However, neither that participant nor another reported any cases in which they needed to deal with this kind of "delayed" appearance of social stigma.

Group work is considered the best treatment modality to address stigma among Latinos by most participants. This was a major unexpected finding of the study because the existing literature does not explore much about group work as a treatment modality for Latinos and when it is done the perception about its effectiveness tends to be more negative than positive. Group work is seen by participants as a privileged space in which the roles of facilitators and members interact to empower clients:

> You have for example a group of Latino women who are coming for depression at a community agency or something. And the facilitators are saying "we are not the experts. Our role here is as facilitators. You guys are the experts about your own experience." They know that the facilitators will not give advice that they refuse to tell them how they should feel or how they can cope. But now they are empowering themselves and figuring out themselves. And that is such an amazing experience—possibly the first experience like this for many Latino women, even Latino men. And I think that might be one of the threads through the reason why I personally love group work so much.

So far, this chapter has discussed the ways in which the data provided by participant clinicians has answered the study research questions, confirmed the study assumptions, and opened new areas for further research. Next, the conclusions and implications of the study will be presented.

Conclusions

This study produced a significant amount of rich data provided by those clinicians who participated in its focus groups. The richness of the data allowed for an in-depth understanding of the perceptions of the participant clinicians in regards to the

topics under study. It confirms that the qualitative research method chosen was adequate to fulfill the purposes of the study.

Participant Latino clinicians recognize social stigma as a cultural reality which does not affect some of their Latino clients, but makes more difficult for others to remain in therapy. Social stigma is not conceptualized by participant clinicians as an issue which needs to be addressed separately in order to be overcome. Rather, it is perceived as one among many other risk factors which may be present in the process of engaging clients in therapy. Participants believe that social stigma does not play a significant role in the dropout of their clients from therapy. On the contrary, most of them believe that even with those clients for whom it is initially an issue, it quickly disappears as a result of the engagement strategies they use at the very beginning of therapy.

All participants follow very similar, intentional strategies to engage their clients in therapy. Participants are not equally intentional in addressing social stigma, though they intuitively and successfully do it when engaging their clients. The most common strategies reported by participants to engage their clients are the use of flexible boundaries in their interactions with Latino clients, and the use of psychoeducation to inform them about the meaning and implications of the therapeutic process. The other strategies are the provision of a safe environment in which client and clinician can work

together, normalizing the therapeutic process, being empathic, and both exploring and emphasizing clients' strengths.

Participants strongly recommend the use of groups as a therapy modality for effectively engaging clients and addressing the issue of social stigma. They also strongly recommended the design of educational campaigns aimed to the Latino community at large, especially in collaboration with churches, to combat the issue of the stigma associated with attending therapy.

Participant clinicians are fully aware of their role as active participants, responsible for addressing all possible obstacles in the process of engaging their clients in the therapeutic process, including social stigma. Participant clinicians are extremely attuned to the nuances of the Latino culture. The cultural meanings which form the world of their clients and themselves are embedded in all of their interventions. Participants are true examples of culturally-responsive clinicians who successfully establish strong therapeutic relationships with their clients, therefore dramatically improving the possibility of positive therapy outcomes for their clients.

Because this study has identified successful ways in which culturally-responsive clinicians consistently engage their clients in therapy, thereby eliminating the possible dropout effect of social stigma, it has made significant first steps in regards to its ultimate aim which was to improve mental health service delivery to the Latino population. There is hope that those strategies consistently used by participants can be

known, learned and replicated by other clinicians increasing the likelihood of similar positive outcomes as those reportedly achieved by participants.

Implications for Practice

It has been recognized in the literature and supported by this study that culturally-responsive clinicians are crucial in order to engage their clients in therapy hence increasing the chances for achieving positive therapeutic outcomes. It has been also recognized that clinicians can be culturally responsive regardless of their coming from the same or a different culture of origin than those of their clients. It implies that being a culturally responsive clinician is a process which can be learned. This study has identified some successful strategies used by experienced Latino clinicians to engage their clients in the therapeutic process. Therefore, it becomes very important to disseminate those successful strategies among other clinicians providing services to Latino clients. By doing this, Latino, experienced clinicians can increase their awareness about those strategies and use them in a more intentional and effective way; and Latino, non-experienced clinicians as well as non-Latino clinicians can develop an understanding of those strategies and eventually internalize and put them into practice with the expectation of strengthening the therapeutic relationship with their Latino clients. The hope is that in the end, the therapy dropout rate among their Latino clients would decrease.

Implications for Further Research

  This study focused on exploring the perspectives of Latino clinicians with at least

five years of experience providing therapy to Latino clients in regards to the research

questions. It became clear that participants narrowed the focus of the study, sharing

their perceptions about the topic of study to Latinos with some specific characteristics

such as being immigrants coming from rural areas, many undocumented, with low-

income, low-education level, low levels of acculturation and lack of knowledge and/or

understanding of the therapeutic process. Further research focused on the perspectives

of clinicians who are Latino but less experienced, as well as non-Latino clinicians is

warranted. Furthermore, a study that examines clients with different characteristics or

combination of characteristics is necessary to obtain a more comprehensive picture of

the therapeutic encounter in regards to the impact of social stigma.

Implications for Social Work Education

  The findings of this study are related to several of the competency areas outlined

by the 2008 Council on Social Work Education (CSWE) Educational Policy and

Accreditation Standards. They are particularly relevant to understanding diversity and

difference in social work practice. The lack of bilingual, culturally-responsive clinicians

has serious implications for social work and other professions aimed at providing care to

vulnerable populations and for those in charge of their education and training. The

findings of this study provide useful material to be incorporated in the different

curricula directed toward capacitating current and future providers of mental health services to Latino clients.

Summary

An exploratory qualitative method design was used to obtain the perceptions of Latino clinicians regarding the impact of social stigma on the therapeutic relationship and the strategies they use to address social stigma when present in therapy. Focus groups were used to obtain the data.

Participants perceived the process of addressing social stigma as being inextricably intertwined with the process of engaging clients in therapy. They identify the use of flexible boundaries, psychoeducation, the provision of a safe environment in which client and clinician can work together, normalizing the therapeutic process, being empathic, and both exploring and emphasizing clients' strengths as their strategies to successfully engage clients in therapy and overcome social stigma. The dissemination of these successful strategies among current and future clinicians seems to be an important tool to increase the likelihood of client retention, permanency in therapy.

While this study contributed to our knowledge regarding impact of social stigma on the therapeutic relationship for Latino clinicians, much remains to be learned regarding this complex issue Among the many areas which merit further study it seems fundamental to obtain the perceptions of less-experienced Latino clinicians and non-

Latino clinicians, as well as the perceptions of Latino clients in therapy regarding to the topic of the study.

The question posed in the title of the study: "The impact of social stigma on the therapeutic relationship for Latino clinicians: The elephant in the room?" can be finally answered. For participants, social stigma is sometimes an invisible, but always recognized and dealt with elephant in the room whose presence does not prevent the therapeutic encounter to move on successfully.

APPENDIX A:

CASE VIGNETTE: MEXICAN

Note: This information has been gathered by you during a first in-person therapy

session.

Claudia is a thirty five year-old woman who was born and raised in a small town in Mexico. She obtained a professional certificate as a massage therapist and worked in that capacity in a rehabilitation center for three years before coming to the United States "looking for a better future." Claudia arrived to the United States nine years ago and has not been able to find a job related to her training and qualifications.

She is currently working as a secretary in a dentist's office. Claudia speaks English fluently but prefers to communicate in Spanish. As a result of a relationship with a former boyfriend, Claudia got pregnant and decided to have an abortion. It happened one and a half years ago. Since then, Claudia says she has experienced guilt and felt depressed. Claudia was raised Catholic and decided to talk to a priest about her feelings. After talking to her twice, he referred Claudia to see you. She felt embarrassed considering talking to a therapist but followed his suggestion and came to her first therapy session. A new appointment has been set.

APPENDIX B:

CASE VIGNETTE: US BORN

Note: This information has been gathered by you during a first in-person therapy session.

Julian was born in the United States forty six years ago and is the son of Salvadorian immigrant parents. His parents came from a rural area in El Salvador and raised their children "according to the traditions and beliefs of their ancestors." Julian is fully bilingual and describes himself as bicultural. Julian is a certified nurse and works in a community hospital. Twenty five years ago, Julian married a Salvadorian immigrant woman. They have two adult children. For several reasons, the marriage has deteriorated to the point that Julian's wife has communicated her decision to divorce him unless he accepts to go to therapy. Julian says that even though he is not a crazy man he wants to save the marriage and has attended the first therapy session with you. A new appointment has been set.

APPENDIX C:

GUIDING QUESTIONS

Guiding questions for the focus group- common for both case vignettes:

1. Do you assess as a routine, the length of time, you think a client might stay in psychotherapy?

2. What are some of the key reasons for staying/leaving?

3. How long do you anticipate this person will remain in psychotherapy and why?

4. How do the client's cultural values affect her/his decision to remain in psychotherapy?

5. What additional information would you like to obtain from the client in order to better respond to the previous questions?

6. How would you ask for that information? What kind of questions or comments would you ask or make to gather the desired information?

7. How have you observed or experienced social stigma manifested in psychotherapy by
your Latino clients?

8. How have your clients operationalized social stigma as a concept?

9. How much effect do you think social stigma has on psychotherapy impasses, client's attrition or abrupt termination of psychotherapy?

10. How have you dealt with those situations?

11. How do you think that being Latina/Latino has impacted your perception of the role social stigma may play in psychotherapy with your Latino clients?

APPENDIX D:

CONSENT FORM FOR FOCUS GROUPS

Project Title: The impact of social stigma on the therapeutic relationship for Latino clinicians: The elephant in the room?

Researcher: Mauricio Cifuentes, LCSW

Faculty Sponsor: Maria Vidal de Haymes, Ph.D.

Introduction:

You are being asked to take part in a research study being conducted by Mauricio Cifuentes for a dissertation under the supervision of Maria Vidal de Haymes, Ph.D. in the Department of Social Work at Loyola University Chicago.

You are a bilingual (English-Spanish) and Latino therapist, practicing in the Chicago metropolitan area, with at least five years of experience providing services to Latino clients in the disciplines of social work, psychology, or counseling. It is expected that a total of 20 clinicians will participate in the study.

Those individuals who at the time of the study have a relationship e.g., administrator-teacher, teacher-student, psychotherapist-client, supervisor-supervisee, supervisor-employee, with either the researcher, Mauricio Cifuentes, LCSW, or the focus group co-facilitator, Ida Roldán, Ph.D., LCSW, are excluded from participation in the study.

Please read this form carefully and ask any questions you may have before deciding whether to participate in the study.

Purpose:

The purpose of this study is to explore (1) the perceptions of Latino mental health service-providers regarding the influence of social stigma in psychotherapy with Latino clients; and (2) the ways Latino mental health clinicians address this issue in their practice. Furthermore, this study intends to consider the role of clinicians in (1) addressing social stigma in psychotherapy and (2) identifying strategies for dealing with this issue. The ultimate aim of this research is to improve mental health service delivery to the Latino population.

Specifically, the research questions for this study are: (1) What is the impact of social stigma on the therapeutic relationship? (2) How do clinicians address social stigma in psychotherapy?

Procedures:

If you agree to be in the study, you will be asked to take part in a focus group that will last 90 minutes and will include between 4 and 7 clinicians. The focus group will be facilitated by the researcher and Ida Roldán, Ph.D., LCSW.

In the focus group you will be asked to read a written case vignette and respond to some open-ended questions. A case vignette is a hypothetical case reflective of real-life situations familiar to participants and suggestive of the matter of exploration. The guiding questions will refer to your assessment of the expected time for Latino clients to remain in therapy, your perception of the reasons Latino clients have to remain in or leave therapy, the influence of clients' cultural values about remaining in therapy, some of your interventions to gather information you consider important from your clients, your perception and direct experiences with the stigma related to remaining in therapy manifested by your Latino clients, your responses in those situations, and the way in which your Latina/o ethnicity has influenced your perceptions about the role of stigma in therapy with your Latino clients. The focus group will take place in one of three different private offices located in the Chicago metropolitan area. The focus group will be audio taped and then transcribed for later analysis.

Risks/Benefits:

There are no foreseeable risks involved in participating in this research beyond those experienced in everyday life.

There are no direct benefits to you by participating in this research. The information obtained is expected to help you and other clinicians more effectively address the issue of social stigma when it appears in therapy with Latino clients. It is also expected that the information obtained will contribute to the improvement of mental health service delivery to the Latino population.

Confidentiality:

All the information you provide is confidential and will not be shared by the researcher with others unless during the focus group you communicate an unethical conduct regarding your involvement with a client. In this case, the policies and procedures in place by professional organizations such as the National Association of Social Workers, and licensing and regulatory bodies of your profession will be followed. They may imply breaking the general rule of confidentiality. While the information you provide will not be shared with outside sources, with the exclusion of the already stated exception, it cannot be guaranteed that other participants in the focus group will not share what you have said outside the focus group setting.

For purposes of confidentiality, your name will not be asked. Instead, you will be identified by number. Every focus group participant will be assigned a tag with a visible number on it, which will remain on display during the session. At the beginning of every session every group member will be asked to introduce herself/himself using the assigned number instead of her/his name. This will be recorded and will provide a reference point for transcription. The group co-facilitators will address group members by number. Other group members will be requested to do the same. The tape recordings will be transcribed and no names at all will be included in the transcriptions. An out-site transcriber will be hired. This individual will sign a confidentiality agreement. The tapes and transcribed materials will be kept locked in a secure location. In the case of electronic files, they will be stored in password protected computers. Only the researcher and the focus groups co-facilitator will have access to the tapes and transcribed notes. The focus groups co-facilitator will sign a confidentiality agreement. When the tapes have been checked for accuracy, they will be destroyed. At the end of the study, the electronic files and transcribed notes will also be destroyed. Your name will never be used or included in any presentations, reports or articles related to this research. When individuals are mentioned, it will be done in a way that disguises their identity.

Voluntary participation:

Participation in this study is voluntary. If you do not want to be in this study, you do not have to participate. Even if you decide to participate, you are free to not answer any question or to withdraw from participation at any time without penalty.

Contacts and Questions:

If you have any questions about this research project, please feel free to contact Mauricio Cifuentes at (773) 849-4709 or the faculty sponsor Dr. Maria Vidal de Haymes at (312) 915-7020.

If you have questions about your rights as a research participant, you may contact the Compliance Manager in Loyola's Office of Research Services at (773) 508-2689.

Statement of consent:

Your signature below indicates that you have read and understood the information provided above, have had an opportunity to ask questions, and agree to participate in this research study. You will be given a copy of this form to keep for your records.

_____
Participant's Signature   Date

_____
Researcher's Signature   Date

APPENDIX E:

REQUEST FOR COLLABORATING ON A RESEARCH PROJECT

(E-MAIL)

Dr/Mr/Mrs Name

Institution or Organization

Ref: Request for collaborating on a research project

You are being contacted to explore the possibility of your Institution/Organization collaborating on a research study being conducted by Mauricio Cifuentes, LCSW for a dissertation under the supervision of Maria Vidal de Haymes, Ph.D. in the Department of Social Work at Loyola University Chicago.

The study is titled "The impact of social stigma on the therapeutic relationship for Latino clinicians: The elephant in the room?" The purpose of the study is to explore (1) the perceptions of Latino mental health service-providers regarding the influence of social stigma in psychotherapy with Latino clients; and (2) the ways Latino mental health clinicians address this issue in their practice. Furthermore, this study intends to consider the role of clinicians in (1) addressing social stigma in psychotherapy and (2) identifying strategies for dealing with this issue. The ultimate aim of this research is to improve mental health service delivery to the Latino population.

The study sample criteria consists of (1) being a bilingual (English-Spanish) and Latino psychotherapist, (2) practicing in the Chicago metropolitan area, (3) with at least five years of experience providing services to Latino clients (4) in the disciplines of social work, psychology, or counseling. It is expected to recruit 20 clinicians. Each one of them will commit to participate in a one-and-a-half-hour focus group. In order to provide more comprehensive and detailed information about the research project, a blank "Consent form for focus groups" is attached.

If your institution/organization agrees to collaborate, the specific request being asked of you consists of (1) forwarding this e-mail and attachment ("Request for collaborating on a research project" and "Consent form for focus groups") to all of the institution/organization members or those who meet the study sample criteria, and (2) asking those clinicians interested in participating in the study to contact the researcher.

If you have any questions about this research project, please feel free to contact the researcher Mauricio Cifuentes or the faculty sponsor Dr. Maria Vidal de Haymes at (312) 915-7020. If you have questions about the rights of research participants, you may contact the Compliance Manager in Loyola's Office of Research Services at (773) 508-2689.

If you agree in collaborating with this project, please inform the researcher, Mauricio Cifuentes, by e-mail at maujoci@yahoo.com, by phone at (773) 849-4709, or by mail at 6007 N. Sheridan Rd. #36 D, Chicago, IL, 60660.

Thank you for your consideration,

Mauricio Cifuentes, LCSW   Maria Vidal de Haymes, Ph.D.

Researcher   Faculty Sponsor

APPENDIX F:

INVITATION TO PARTICIPATE ON A RESEARCH PROJECT-ONLINE SOURCE

City and date

Dr/Mr/Mrs Name

Address

Ref: Invitation to participate on a research project

You are being invited to participate on a research study being conducted by Mauricio Cifuentes, LCSW for a dissertation under the supervision of Maria Vidal de Haymes, Ph.D. in the Department of Social Work at Loyola University Chicago.

The study is titled "The impact of social stigma on the therapeutic relationship for Latino clinicians: The elephant in the room?" The purpose of the study is to explore (1) the perceptions of Latino mental health service-providers regarding the influence of social stigma in psychotherapy with Latino clients; and (2) the ways Latino mental health clinicians address this issue in their practice. Furthermore, this study intends to consider the role of clinicians in (1) addressing social stigma in psychotherapy and (2) identifying strategies for dealing with this issue. The ultimate aim of this research is to improve mental health service delivery to the Latino population.

It is expected that 20 clinicians will be recruited. Each recruited clinician commits to participate in one, one-and-a-half-hour focus group involving between 4 to 7 clinicians each. In order to provide more comprehensive and detailed information about the research project, a blank consent form is enclosed with this letter for your review.

You are being invited to participate because according to the information you have posted online at Psychologytoday.com you meet the study sample criteria consisting of (1) being a bilingual (English-Spanish) and Latino psychotherapist, (2) practicing in the Chicago metropolitan area, (3) with at least five years of experience providing services to Latino clients (4) in the disciplines of social work, psychology, or counseling.

Those individuals who at the time of the study have a relationship e.g., administrator-teacher, teacher-student, psychotherapist-client, supervisor-supervisee, supervisor-employee, with either the researcher, Mauricio Cifuentes, LCSW, or the focus group co-facilitator, Ida Roldán, Ph.D., LCSW, are excluded from participation in the study.

If you have any questions about this research project, please feel free to contact the researcher Mauricio Cifuentes or the faculty sponsor Dr. Maria Vidal de Haymes at (312) 915-7020. If you have questions about the rights of research participants, you may contact the Compliance Manager in Loyola's Office of Research Services at (773) 508-2689.

If you are interested in participating in this research, please contact the researcher, Mauricio Cifuentes, either by phone at (773) 849-4709 or by e-mail at maujoci@yahoo.com.

Thank you for your consideration,

Mauricio Cifuentes, LCSW　　　　　　　Maria Vidal de Haymes, Ph.D.

Researcher　　　　　　　　　　　　　　Faculty Sponsor

APPENDIX G:

INVITATION TO PARTICIPATE ON A RESEARCH PROJECT-REFERRAL

City and date

Dr/Mr/Mrs Name

Address

Ref: Invitation to participate on a research project

You are being invited to participate on a research study being conducted by Mauricio Cifuentes, LCSW for a dissertation under the supervision of Maria Vidal de Haymes, Ph.D. in the Department of Social Work at Loyola University Chicago.

You are being invited to participate because your name has been suggested by a colleague, institution/organization with which you are affiliated, as someone who possibly meets the study sample criteria consisting of (1) being a bilingual (English-Spanish) and Latino psychotherapist, (2) practicing in the Chicago metropolitan area, (3) with at least five years of experience providing services to Latino clients (4) in the disciplines of social work, psychology, or counseling.

Those individuals who at the time of the study have a relationship e.g., administrator-teacher, teacher-student, psychotherapist-client, supervisor-supervisee, supervisor-employee, with either the researcher, Mauricio Cifuentes, LCSW, or the focus group co-facilitator, Ida Roldán, Ph.D., LCSW, are excluded from participation in the study.

The study is titled "The impact of social stigma on the therapeutic relationship for Latino clinicians: The elephant in the room?" The purpose of the study is to explore (1) the perceptions of Latino mental health service-providers regarding the influence of social stigma in psychotherapy with Latino clients; and (2) the ways Latino mental health clinicians address this issue in their practice. Furthermore, this study intends to consider the role of clinicians in (1) addressing social stigma in psychotherapy and (2) identifying strategies for dealing with this issue. The ultimate aim of this research is to improve mental health service delivery to the Latino population.

It is expected that 20 clinicians will be recruited. Each recruited clinician commits to participate in one, one-and-a-half-hour focus group involving between 4 to 7 clinicians each. In order to provide more comprehensive and detailed information about the research project, a blank consent form is enclosed with this letter for your review.

 If you have any questions about this research project, please feel free to contact the researcher Mauricio Cifuentes or the faculty sponsor Dr. Maria Vidal de Haymes at (312) 915-7020. If you have questions about the rights of research participants, you may contact the Compliance Manager in Loyola's Office of Research Services at (773) 508-2689.

If you are interested in participating in this research, please contact the researcher, Mauricio Cifuentes, either by phone at (773) 849-4709 or by e-mail at maujoci@yahoo.com.

Thank you for your consideration,

Mauricio Cifuentes, LCSW   Maria Vidal de Haymes, Ph.D.

Researcher   Faculty Sponsor

APPENDIX H:

CONFIDENTIALITY AGREEMENT WITH TRANSCRIBER

City and date

(Name of the transcriber), agrees to transcribe the focus group sessions audio-taped as part of a research project titled "The impact of social stigma on the therapeutic relationship for Latino clinicians: The elephant in the room?" conducted by Mauricio Cifuentes, LCSW for a dissertation under the supervision of Maria Vidal de Haymes, Ph.D. in the Department of Social Work at Loyola University Chicago.

The transcriber agrees that all the information related to the content of the focus group sessions is confidential. Therefore, she/he commits to keep locked in a secure location the tapes and transcribed materials. In the case of electronic files, she/he commits to keep them stored in password-protected computers. It is understood that only the researcher and the focus groups co-facilitator will have access to the tapes and transcribed notes. All the tapes, electronic files and transcribed notes will be given to the researcher and the transcriber will not keep a copy of any of them.

Name of the transcriber   Mauricio Cifuentes, LCSW

The transcriber   The researcher

APPENDIX I:

CONFIDENTIALITY AGREEMENT WITH FOCUS GROUPS CO-FACILITATOR

City and date

Ida Roldán, Ph.D., LCSW and Mauricio Cifuentes, LCSW do agree to co-facilitate the focus group sessions which will be conducted as part of a research project titled "The impact of social stigma on the therapeutic relationship for Latino clinicians: The elephant in the room?"

This research project is a dissertation conducted by Mauricio Cifuentes under the supervision of Maria Vidal de Haymes, Ph.D. in the Department of Social Work at Loyola University Chicago.

Ida Roldán, Ph.D., LCSW will meet the focus groups participants and will also have access to the audio-tapes, transcriptions and electronic files resulting from the focus groups sessions. Dr. Roldán acknowledges that all the information related to the content of the focus group sessions is confidential.

Both co-facilitators commit to keep confidential the identities of the participants. In the case of presentations, reports or articles that may be given or written by the co-facilitators about this research, the name of the focus groups participants will never be used or included. When individuals are mentioned, it will be done so in a way which disguises their identity.

Ida Roldán, Ph.D., LCSW   Mauricio Cifuentes, LCSW

The co-facilitator   The researcher

APPENDIX J:

CODE BOOK

TREE A: ENGAGEMENT RISK/FACILITATING FACTORS
DEFINITION: Factors which may facilitate or prevent the engagement process to successfully occur.
NODE A1: Clinician Culture
DEFINITION: How coming to and remaining in therapy may be influenced by the culture of the clinician.
EXAMPLE: *"Being Latina in itself does make a difference. I think just looking the same way they see someone that has kind of the same color hair or the eyes—that does make a difference. It provides that comfort just coming in."*
NODE A2: Stigma Gender
DEFINITION: How the gender of clients and clinicians may influence the engagement process and the issue of stigma in therapy.
EXAMPLE: *"Any time you can identify with the therapist on any level, gender and ethnicity, it helps to establish rapport."*
NODE A3: Stigma Involuntary Client
DEFINITION: The possible stigmatizing effect of going to therapy because of others' initiative or pressure and how it affects the engagement process.
EXAMPLE: *"They come to see what it is going to be like and to see if "I'm going to stay, if I want to engage."*
NODE A4: Stigma Mental Health System
DEFINITION: The impact that the possible stigma associated with being involved with the mental health system, i.e., government entities, insurance companies and diagnosis may have on remaining or leaving therapy.

EXAMPLE: *"We get confused with DCFS (Department of Children and Families of the State of Illinois), especially for Latino families. They are scared that we work for the state, that somehow we are connected to immigration, that you know, we are asking too many questions. There is a piece of it, especially if they have had any threats from DCFS, or any kind of past experiences. But I think that is part of the relationship, that at the beginning you have to work really hard with them to convince them that you are*

there to help them to stay out of DCFS or some other systems. They do not understand the systems and they just see you as an authority that is related to something that could get them in trouble whether it is immigration or DCFS and so."

NODE A5: Client Socio-Economic Status

DEFINITION: Characteristics of those Latinos with whom participant clinicians have or have had therapeutic relationships.

EXAMPLE: *"They are low-income, low-education level, from the fields, from the mountains,""mostly females,""very low acculturation."*

NODE A6: Social Stigma

DEFINITION: The different ways in which social stigma is presented or not by clients and/or it becomes evident for participant clinicians with their clients.

EXAMPLE: *"I think the most important thing I consider when thinking about the impact of social stigma is the feelings clients may experience of being crazy or sick or weak. I guess those are the main things, that somebody is deficient and weak for going to therapy."*

NODE A7: Stigma Duration

DEFINITION: How long the social stigma associated with being in therapy may remain as a risk factor for the therapeutic process.

EXAMPLE: *"From my experience working with clients, I think that if you establish a successful good connection in the first session, that issue (stigma) disappears very fast. And if you have a client who is consistent and after the first session continues to come, it never comes up as an issue."*

TREE B: ADDRESSING RISK/FACILITATING FACTORS

DEFINITION: Ways in which those factors facilitating the engagement of clients can be maximized and those risk factors that may prevent the engagement process to successfully occur can be avoided or overcome.

NODE B1: Clinician Role Engagement

DEFINITION: What participant clinicians perceive to be their role in order to engage clients in the therapeutic process.

EXAMPLE: *"If we really want for her to stay, it is the role of the clinician to do some*

work to make sure that she is coming back.”

NODE B2: Empathy

DEFINITION: The ability to be attuned and responsive to the clients' needs, to be "in you[r] client's shoes."

EXAMPLE: *"It is more like, "let's talk about all the things which have happened this year or let's talk about how it felt when those things happened." Then, you begin to know that empathy is what really builds the relationship on that we are not here to judge, we are not here to make assumptions or criticize. Most of the time they just need to tell their story to someone."*

NODE B3: Environment

DEFINITION: The need to provide an environment which offers safety to the client and fosters team work between client and clinician.

EXAMPLE: *"In general, it is about trying to make them feel safer; that they are coming to a safe place and that they will be exploring and learning together, that we are working together."*

NODE B4: Normalizing

DEFINITION: The different ways in which participants normalize therapy and how it helps to de-stigmatize the process facilitating it to move forward.

EXAMPLE: *"I think that we try to normalize what we are doing with clients trying to make it seem like if it is nothing out of this world."*

NODE B5: Strengths

DEFINITION: The exploration in therapy of the coping mechanisms and strengths used by clients to deal with their issues.

EXAMPLE: *"Early on, as part of the engagement process, one needs to access the strengths to counter this stigma the person may feel of being weak and crazy for coming to therapy. Instead of pathologizing the client you focus on the strengths. It makes the engagement a lot easier. You challenge the stigma and increase the engagement with the client."*

NODE B6: Stigma Psychoeducation
DEFINITION: To providing education as a way to engage clients in the therapeutic process and to deal with the social stigma which may be associated with being in therapy.
EXAMPLE: *"I go for the basics, you know, what is a doctor, what is a psychiatrist, what is a counselor, what is a social worker. I spend some time explaining to them what we do because most of the time they do not have a preference, they cannot know what they are doing here. So part of the process is kind of educational in nature to explain to them what they are supposed to be doing there."*

NODE B7: Clinician Role Boundaries
DEFINITION: how the expectations about the clinician's role in therapy and the way the clinician responds to them may impact the engagement process and the issue of stigma.
EXAMPLE: *"Another thing I think is interesting when engaging with Latino families, something different than when working with other cultures, in my experience, is that Latino clients want to know where I am from, they want to know what generation I am, and this is an interesting aspect of self-disclosure because I share. I think that whether clients stick or not in therapy has much to do with finding some common ground with the clinician. The want to know if I eat tamales (a kind of typical food); they want to know more about me before engaging further. And I feel that if I do not share—I mean certainly what is appropriate—I would lose them, I would be cutting the relationship off. And so, I share. I share where my parents are from, that I was born here. Those kinds of things. And I think that addresses stigma. You know, how much are you like me, how different are you from me, how are you going to help me and my family? And I think that a lot of that "dance" happens at the beginning of therapy."*

NODE B8: Groups
DEFINITION: Different aspects of the use of group therapy—understood in a broad sense which may include not only therapeutic but also psycho-educational and support groups—as a privileged way to engage Latino clients in therapy and to deal with the stigma which may be associated with it.

EXAMPLE: *What I was about to say is that that is a whole other study in the future, because just anecdotally, right now anecdotally you have 3, 4, 5 people in this room who have had experienced the effectiveness of group process as a clinical intervention with Latinos."*

TREE C: THERAPY DROPOUT FACTORS

DEFINITION: The factors clinician participants perceive as determinant for clients' dropout.

NODE C1: General Dropout Factors

DEFINITION: What participant clinicians understand as dropping out of therapy and those factors, other than stigma, which can be associated with abruptly leaving therapy.

EXAMPLE: *"It is hard to define "dropping-offs" and "dropping-outs." What I see with Latinos is that they come for the sessions they may think they need and that is it, but they really connect with you and then they continue coming all their lives on and off. And it seems to be unique or not unique but particular to Latinos."*

NODE C2: Stigma Dropout Factor

DEFINITION: The role social stigma may or may not play as a factor for Latino clients to drop out of therapy from the perspective of participants.

EXAMPLE: *"I never think that (dropping-out) it is because stigma, to be perfectly honest. I do not think that it has ever crossed my mind that I thought "Oh, it was stigma that is why they did not come back." Now, that they did not show up the first time because of that, possibly. But when they do not show up for the second appointment, then, I do not think they are not coming because it is stigmatizing them."*

APPENDIX K:

IRB APPROVAL LETTER

LOYOLA
UNIVERSITY CHICAGO
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AD · MAIOREM · DEI · GLORIAM

Research Services
Institutional Review Board for The Protection of Human Subjects
Lakeside
Lake Shore Campus
1032 W. Sheridan Road | Chicago, Illinois 60660

August 3, 2009

Dear Mauricio Cifuentes,

Thank you for submitting the research project entitled: The impact of social stigma on therapeutic relationship for Latino clinicians: The elephant in the room?, for *expedited review* by the Institutional Review Board for the Protection of Human Subjects. After careful examination of the materials you submitted, we have **approved** this project as described for a period of one year. The IRB has approved the final version of the consent form(s). Official stamped version(s) are attached to the email you received. Please make copies of the IRB approved consent form(s) for use in obtaining consent from participants.

Approximately eleven months from your initial review date, you will receive a renewal notice stating that approval of your project is about to expire. This notice will give you detailed instructions for submitting a renewal application. If you do not submit a renewal application prior to August 3, 2010, your approval will automatically lapse and your project will be suspended. **When a project is suspended, no more research or writing regarding human subjects may be done until the project is reevaluated and re-approved.** I recommend that you respond to these annual renewals in a complete and timely fashion.

This review procedure, administered by the IRB, in no way absolves you, the researcher, from the obligation to immediately inform the IRB in writing if you would like to change aspects of your approved project (please consult our website for specific instructions). You, the researcher, are respectfully reminded that the University's ability to support its researchers in litigation is dependent upon conformity with continuing approval for their work. Should you have questions regarding this letter or general procedures, please contact the Compliance Manager at (773) 508-2689. Please quote File **#74211** if this project is specifically involved.

With best wishes for the success of your work,

Raymond H. Dye Jr.

Dr. Raymond H. Dye, Jr.
Chair, Institutional Review Board

CC: Dr. Maria Vidal de Haymes -Social Work

http://www.luc.edu/ors/irb_home.shtml

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VITA

Mauricio Cifuentes was born and raised in Cali, Colombia. He received a Juris

Doctor degree in 1985 and a specialization in Labor Law in 1986, from the Pontificia

Universidad Javeriana in Bogota, Colombia. After practicing as a corporate labor lawyer

and teaching labor law for almost twenty years in his country of origin, he moved to

Chicago, Illinois to attend Loyola University Chicago where he received a Master's

degree in Social Work in 2003. He graduated with a 4.0 GPA and was inducted as a

member of Alpha Sigma Nu, the National Jesuit Honor Society. While at Loyola,

attending the Master's program, Mauricio was awarded the Lester Czernak Scholarship

for Outstanding Minorities, and the President's Medallion.   As a result of a clinical paper

written in his last year at the Master's program, he became a national winner of the

Judith Holm Memorial Award, awarded by The American Board of Examiners in Clinical

Social Work. After graduating from the Master's program, Mauricio obtained a

Certificate in Clinical Practice with LGBT Individuals and Their Families granted by The

Chicago Center for Family Health.

Right after graduating from Loyola, Mauricio worked for nearly six years for St.

Anthony Hospital in Chicago, developing and administering a mental health program

called Despierta (which means "wake up" in English). The program was designed to

provide mental health services (individual, couples, family and group therapy) to adult

and older adult Latino immigrants, who deal with a wide array of mental health issues,

especially, though not exclusively, those derived from complex trauma. As a licensed

clinical social worker, Mauricio provided direct clinical services and supervised social

work interns at Despierta.

Currently, Mauricio works in private practice providing individual, couples, family

and group therapy to adolescents, adults, and older adults, both LGBT and

heterosexuals, most of them Latino immigrants but also to US-born Latinos and

Caucasian clients. He is also a faculty member at the Institute for Clinical Social Work

providing clinical supervision and teaching as an adjunct professor.

Cultural responsiveness, group work, and child welfare have been areas of

particular interest for Mauricio. Most of his publications and presentations are related

to these topics.   In 2006, he co-authored "Culturally Responsive Child Welfare Practice

with Latino Children and Families: A Professional Training Curriculum," which was

published by the U.S. Department of Health and Human Services (CFDA: 93:648, Child

Welfare Training Projects). Mauricio participated in this publication as a result of being

a recipient of the Latino Child Welfare Initiative Fellowship, awarded by the U.S.

Department of Health and Human Services. This fellowship funded his doctoral studies

for the years 2005-2006 and 2006-2007. In 2004, Mauricio authored the article

"Poverty, crisis, and resilience of spirit" published by the Journal of Poverty: Innovations on Social, Political & Economic Inequalities, 8(4), 125-128.

Mauricio has presented in several conferences. At the 31st Annual International Symposia on Social Work with Groups, held in Chicago in 2009, he presented the paper co-authored with Dr. Carlean Gilbert titled "Mutual aid groups of Mexican immigrant survivors of traumatic experiences: Growing and healing in a foreign culture." A precursor of this paper titled "Mexican immigrant survivors of traumatic experiences: Healing by mutual aid groups" was presented in 2007 at the Congreso Internacional Sobre Migración, held by the Universidad Iberoamericana in León, Guanajuato, México. In 2009, at the First Annual Institute Day for the IDCFS Asian Advisory Council, sponsored by the Illinois Department of Children and Family Services, Mauricio presented the paper titled "Immigrant and refugee trauma." In 2007, at the 18th Annual Hispanic Family Institute, sponsored by the Illinois Department of Children and Family Services, Mauricio presented the paper "Cultural considerations for clinical practice with first generation Mexican immigrants." In 2006, at the 17th Annual Hispanic Family Institute, sponsored by the Illinois Department of Children and Family Services, he presented with Dr. Maria Vidal-Haymes the paper titled "Child welfare practice in a Latino multi-cultural context: Working effectively with Latino families."

Mauricio is a member of the Latino Mental Health Providers Network, the Loyola University Chicago School of Social Work Alumni Board, the Association for the

Advancement of Social Work with Groups (AASWG), the Safety Review Board of the

Missionaries of the Sacred Heart, USA Province, and the National Association of Social

Workers. He has served as an article reviewer for Protecting Children, the Journal of the

American Humane Association, and for the Journal of Poverty: Innovations on social,

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DISSERTATION APPROVAL SHEET

The dissertation submitted by Mauricio J. Cifuentes has been read and approved by the following committee:

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The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

_____   _____
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